

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 3 3 5 4

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) PAUL HENRY BARNARD			2a. DATE OF DEATH MONTH DAY YEAR December 14, 1986		2b. HOUR 11:30A M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 11 1916		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Paper Mill
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Garrett		13c. CITY OR TOWN Swanton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Howard Barnett		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Duckworth		13e. STREET ADDRESS / ZIP CODE Rt 1 Swanton Md. 21561		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W. W. 2 214-12-3735		17. INFORMANT ADDRESS Mrs Phyllis Barnard Rt 1 Swanton Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lung Cancer, Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>etc</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.						
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSE OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERWAY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> TO DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> N/A		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A N/A		
22a. I certify that (I) (this hospital) attended the deceased from <u>12/14/86</u> , 19____, to <u>12/14/86</u> , 19____, that (I) (we) last saw the deceased alive on <u>12/14/86</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.						
22b. SIGNATURE <u>Dr. Howard Diener</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Howard Diener		22e. ADDRESS Memorial Hospital & Medical Center Cumberland, MD 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/17/86		23c. NAME OF CEMETERY OR CREMATORY Garrett Memorial Garden		23d. LOCATION CITY OR TOWN COUNTY Oakland Garrett Md.
24. FUNERAL DIRECTOR NAME Roal Funeral Service Westernport Md.				25a. DATE REC'D. BY REGISTRAR DEC 22 1986		25b. REGISTRAR'S SIGNATURE <u>Julia D. ...</u>

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET JANE BARNES			2a. DATE OF DEATH MONTH DAY YEAR December 20, 1986		2b. HOUR 9:00	
4. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JUNE 2 1916		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS (LAST BIRTHDAY)) 70 YRS.		
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.		
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE PENNA		13b. CITY OR TOWN ARTEMAS		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST ALRAH CLINGERMAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JESSIE SHIPLEY		13d. STREET ADDRESS / ZIP CODE RFD# 1 BOX# 22-B 99999		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 214-07-2451		17. INFORMANT KENNETH BARNES ARTEMAS PENNA 17211 BOX 51		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic obstructive Pulmonary Disease DUE TO, OR AS A CONSEQUENCE OF (c) Cor pulmonale.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) show the body after death.						
22b. SIGNATURE <i>Dr. H. C. Merrick</i>		22c. DATE SIGNED 12/21/86		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. H. C. Merrick		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC 22 1986		23c. NAME OF CEMETERY OR CREMATORY FAIRVIEW CEMETERY		
24. FUNERAL DIRECTOR NAME SILCOX-MERRITT FUNERAL HOME CUMBERLAND MARYLAND		25a. DATE REC'D. BY REGISTRAR DEC 23 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Darden-Randall</i>		

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William G. Knight Cumberland, MD
 Dec. 17, 1986 St. Marys Cath. & Cumberland Allegany MD

Charles I. Beck Annie Wolf
 214-05-5010 Mary E. Brady Cumberland, MD

MD Allegany Cumberland AK 103 Decatur St. 21502
 Cumberland 103 Decatur St. Ret Brewer Worker Beer Co.

male white Jun. 20, 1902 84

Laymond I. Beck, Sr.

027357 DEC 17 1986

FOR
STATE
REGISTRAR230 Baltimore St
Cumberland, MD 21502Leasure-Stein Funeral Home
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Julia Marie Becker			2a. DATE OF DEATH MONTH DAY YEAR December 10, 1986		2b. HOUR P 11:25M
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR March 5, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County, MD.	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Buyer		12b. KIND OF BUSINESS OR INDUSTRY Retail
13a. STATE Maryland		13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Patrick McGraw		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Margaret Behan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --		17. INFORMANT ADDRESS John Lewis Becker same as 13a-e.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET CITY OR TOWN COUNTY STATE22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last
saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING
PHYSICIAN ☒MEDICAL
DIRECTOR ☐STAFF
PHYSICIAN ☐

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

BMG

BMG 912 Seton Drive, Cumberland, MD 21502

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial23b. DATE
12/13/8623c. NAME OF CEMETERY OR CREMATORY
St. Patricks23d. LOCATION
CITY OR TOWN COUNTY STATE

Cumberland Allegany MD

24. FUNERAL DIRECTOR
NAME

Leasure-Stein Funeral Home

230 Baltimore Ave. Cumberland, MD 21502

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

DEC 16 1986

Julia Dismore-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remain with the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 48 shows any injury, or other traumatic event, the medical examiner must be notified at once.

OFFICE OF THE SECRETARY

WASHINGTON, D.C.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 3 3 5 8

DECEASED NAME				2a. DATE OF DEATH				2b. HOUR	
(TYPE OR PRINT)				MONTH DAY YEAR				A M	
GILBERT P BEEMAN				December 19, 1986				2:40	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. IF UNDER 1 YEAR	
MALE		WHITE		APRIL 9, 1913		73		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Allegany MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR	
Cumberland		Memorial Hospital				GLASS WORKER		PLATE GLASS	
13a. USUAL RESIDENCE				13b. STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MARYLAND				ALLEGANY		FROSTBURG		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS / ZIP CODE			
PHILANDER BEEMAN				EMMA CROFT		90 LINDEN ST., 21532			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES)				W.W. 2 214-07-0754		EDNA G. BEEMAN, 90 LINDEN ST., FROSTBURG, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Myocardial infarction									
DUE TO, OR AS A CONSEQUENCE OF (b)									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED			
				HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED				21e. PLACE OF INJURY		21f. LOCATION			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/18/86 to 12/19/86, that (I) (we) last saw the deceased alive on 12/18/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE				22c. DATE SIGNED	
Dr. Saheta				MD				12/19/86	
22d. PHYSICIAN'S NAME				22e. ADDRESS					
Dr. Saheta				Memorial Hospital Cumberland, Md. 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
BURIAL				DEC. 22, 1986		RESTLAWN MEMORIAL GDNS.		CITY OR TOWN COUNTY STATE	
								ALLEGANY, MD.	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE	
DURST FUNERAL HOME, FROSTBURG, MD. 21532									

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DEC 24 1986

CHIEF

STATE OF TEXAS
COUNTY OF DALLAS
I, the undersigned, Clerk of the County of Dallas, State of Texas, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of the County of Dallas, State of Texas, this 1st day of January, 1900.

[Handwritten signature]
Clerk of the County of Dallas, State of Texas

WITNESSED my hand and the seal of the County of Dallas, State of Texas, this 1st day of January, 1900.

028029 DEC 1986

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

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REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELSIE MARIE BITTINGER			2a. DATE OF DEATH MONTH DAY YEAR December 14, 1986		2b. HOUR P M 9:20		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8/28/1914		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 72	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) cook		12b. KIND OF BUSINESS OR INDUSTRY Restaurant	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Garrett		13c. CITY OR TOWN Friendsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Route 1, Apt D-4 21531	
14. FATHER'S NAME FIRST MIDDLE LAST Silas Silas Bittinger				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Maude Miller				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 217-18-4370				17. INFORMANT Larry A. Bittinger				ADDRESS Route 1, Box 91A Friendsville, MD 21531			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Diabetes Mellitus			
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19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from 11-27 , 19 86 , to 12-14 , 19 86 , that (I) (we) last saw the deceased alive on 12-14 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.	
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22b. SIGNATURE Homer J. Barrera		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-15-86	
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22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Barrera		22e. ADDRESS Memorial Hospital Medical Building Cumberland, Md. 21502	
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23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/17/86		23c. NAME OF CEMETERY OR CREMATORY Grantsville Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Grantsville, Garrett, Maryland	
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24. FUNERAL DIRECTOR NAME D. J. Newman		ADDRESS Grantsville, MD		25. DATE REC'D. BY REGISTRAR DEC 22 1986		26. REGISTRAR'S SIGNATURE Julia Sanchez-Randall	
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove chapters 1 and 2 (should be filed within 72 hours after death) with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, a medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

HAFER FUNERAL HOME

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 3 3 6 0

REG. NO.

1. FOR
STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) BRUCE ALBERT BOWER			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 6, 1986		2b. HOUR 05:45AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec. 21, 1903	6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.		
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Rubber
13a. STATE Maryland			13b. COUNTY Allegany	13c. CITY OR TOWN LaVale	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST William Bower			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Emerick		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 217106690	17. INFORMANT ADDRESS Donald E. Bower - LaVale, MD		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Acute Renal Failure

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Diffuse Arteriosclerotic CV Disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Nov. 28, 1986 to Dec 6, 1986 , that (I) (we) last saw the deceased alive on Dec 6, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Uromiles MD		DEGREE		22c. DATE SIGNED 12/8/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VELANDIA, URIEL, M.D.		22e. ADDRESS 924 SETON DRIVE CUMBERLAND, MD. 21502			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Dec. 9, 1986	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Bur. Park	23d. LOCATION CITY OR TOWN COUNTY Cumberland, Alleg., MD
24. FUNERAL DIRECTOR NAME John J. Hafer, Jr. LaVale, MD		25a. DATE REC'D. BY REGISTRAR DEC 11 1986	
		25b. REGISTRAR'S SIGNATURE Deborah R. Rouse	

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PAUL GARRETT BROWN			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 21, 1986		2b. HOUR 9:48 a
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR October 11, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer	12b. KIND OF BUSINESS OR INDUSTRY Bell & Howell	
13a. STATE Maryland			13b. CITY OR TOWN Allegany	13c. STREET ADDRESS / ZIP CODE 10 Liberty St. Cumb., MD 21502	
14. FATHER'S NAME FIRST MIDDLE LAST Herman G. Brown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizina M. Hershaw			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 304-03-6582		17. INFORMANT ADDRESS Barbara Seymour 20 Buchanan Ave. LaVale, MD 21502	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <u>Conjunctive Heart Failure</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12-18</u> , 19 <u>86</u> , to <u>12-21</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12-21</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE		22c. DATE SIGNED 12-22-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. R. Barrera		22e. ADDRESS The Memorial Hospital Medical Building Memorial Ave., Cumberland, Md. 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/24/86		23c. NAME OF CEMETERY OR CREMATORY Sunset Mem. Park	
23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD					
24. FUNERAL DIRECTOR NAME ADDRESS George-Upchurch Funeral Home 202 Greene St. Cumberland, MD 21502				25a. DATE REC'D. BY REGISTRAR DEC 30 1986	
				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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REG. NO. 8 6 3 3 3 6 2

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET DEVENE BYERS			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 21, 1986		2b. HOUR MIN 11:00^a_M			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 07-28-1916		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 70 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.		
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. STATE MD				13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE 347 1/2 Bedford Street/21502				
14. FATHER'S NAME FIRST MIDDLE LAST Austin O. Fortney				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ollie F. McKenzie				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 220-10-7511		17. INFORMANT ADDRESS Mr. Randy R. Ross, Svern, MD - son				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Underlying Cause DUE TO, OR AS A CONSEQUENCE OF (c) Cardiac Arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN DETERMINING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12-17 19 86 , to 12-21 19 86 , that (I) (we) last saw the deceased alive on 12-21 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Allen P. Jones				22c. DATE SIGNED 12/23/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. T. Elder				22e. ADDRESS The Memorial Hospital Medical Building Memorial Ave., Cumberland, Md. 21502	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-23-1986		23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Lonaconing Allegany MD		24. FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, MD 21502			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DEC 29 1986

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
John		A.		Calhoun				12-31		19		86		8:00A			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
male	white	10-02-1926		60 YRS.						12-31		19		86		9:35A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
PA		USA						Allegany County, MD									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Rawlings		Route 3 Box 178-A		ret. welder		railroad											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
MD		Allegany		Rawlings		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Route 3 Box 178-A/21502									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Charles Calhoun		Mae Ketterman															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
yes		WW II		219-14-5785		Mrs. Katie M. Calhoun, Rawlings, MD - wife											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Arteriosclerosis Cardiovascular Heart Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
						DUE TO, OR AS A CONSEQUENCE OF											
						(b)		DUE TO, OR AS A CONSEQUENCE OF									
						(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
				YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		HOUR A.M. MONTH DAY YEAR															
		P.M. 19															
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION													
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held an		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input checked="" type="checkbox"/>		and in my opinion									
death resulted from:		Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		TITLE (SPECIFY)		M.D.		MEDICAL EXAMINER		DATE SIGNED									
Dr. Francisco Reyes		Deputy						12/31/86									
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
Dr. Francisco Reyes		Seton Drive, Cumberland, MD															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION											
Burial		01-03-1987		Restlawn Memorial Pk.		Cumberland Allegany MD											
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
James F. Scarpelli		Cumberland, MD 21502				JAN 8 1987		[Signature]									

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FOR
STATE
REGISTRAR

DECEASED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked (c), item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARGARET MIDDLE S. LAST CANNON			2a. DATE OF DEATH MONTH DAY YEAR December 13, 1986		2b. HOUR 9:45 A.M.	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 11-07-1921		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY own home
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Allegany 13c. CITY OR TOWN Cumberland			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 416 Franklin Street/21502	
14. FATHER'S NAME FIRST MIDDLE LAST Harry W. Dawson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mattie Waxler			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 215-42-4388		17. INFORMANT ADDRESS Mrs. Margaret J. Smith, Cumberland, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mesenteric Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis of Mesenteric Arteries DUE TO, OR AS A CONSEQUENCE OF (c) N/A Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Unknown
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a N/A						
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) N/A		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on <u>12/13/86</u> , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Howard Diener</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/13/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Howard Diener		22e. ADDRESS Memorial Hospital & Medical Center Cumberland, MD 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-16-1986		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Short Gap WV
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502		24b. ADDRESS DEC 18 1986 Julia Dendron-Randall				

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
JERRY GILBERT CLISE Sr.			Dec. 10, 1986			1702P.M.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS) (LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
MALE	White	01 18 34	52 YRS.			MONTHS DAYS HOURS MIN.		
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	8b. CITIZEN OF WHAT COUNTRY?	9. BALTIMORE CITY OR COUNTY OF DEATH		10. USUAL OCCUPATION				
Md	USA	ALLEGANY COUNTY MD		Service Station Gasoline				
11. CITY OR TOWN OF DEATH	12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13a. INSIDE CITY LIMITS?			13b. STREET ADDRESS / ZIP CODE		
CUMBERLAND	MEMORIAL HOSPITAL		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			RT 1 BOX 538 21532		
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME		16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
Arthur	Ethel Williams		17a. STATE 17b. COUNTY 17c. CITY OR TOWN					
			MARYLAND ALLEGANY FROSTBURG					
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)			18b. SOCIAL SECURITY NO.			19. INFORMANT		
No			None 220-32-2728			Martha Clise Rt. 1, Box 538		
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (d) _____								
21a. DATE OF OPERATION			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			22a. AUTOPSY?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			23b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			24. HOW INJURY OCCURRED (Enter nature of injury in item 18, Part 1 or Part 2)		
25a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			25b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			26. LOCATION STREET CITY OR TOWN COUNTY STATE		
27a. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on _____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
27b. SIGNATURE			27c. DEGREE			27d. DATE SIGNED		
DR. GUY FISCUS			ATTENDING PHYSICIAN			12/11/86		
27e. PHYSICIAN'S NAME (TYPE OR PRINT)			27f. ADDRESS			27g. MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
			Memorial Hosp. Med. Building			Cumberland, Md.		
28a. BURIAL, CREMATION, REMOVAL			28b. DATE			28c. NAME OF CEMETERY OR CREMATORY		
Burial			12-13-86			Laurel Hill Cemetery		
29a. FUNERAL DIRECTOR			29b. DATE REC'D. BY REGISTRAR			29c. REGISTRAR'S SIGNATURE		
Eichmorn-McKenzie Funeral Home, Lonaconing, Md.			DEC 15 1986			Julia Tindon-Randall		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 1973 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified above.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) ROY JACOB CRITES					2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 28, 1986				2b. HOUR 5:45A_M				
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 03-15-1913		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.							
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		12b. KIND OF BUSINESS OR INDUSTRY Petroleum Co.					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE WV		13b. COUNTY Mineral		13c. CITY OR TOWN Wiley Ford		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE none/26767-99999					
14. FATHER'S NAME FIRST MIDDLE LAST Jesse Crites					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Weese								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220-10-9187		17. INFORMANT ADDRESS Mrs. Amelia L. Crites, Wiley Ford, WV - wife								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA DUE TO, OR AS A CONSEQUENCE OF (b) atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 days			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (1) (this hospital) attended the deceased from 12/19/86 , to 12/28/86 , that (1) (we) last saw the deceased alive on 12/27/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.													
22b. SIGNATURE T. Williams					DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED 12/29/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. T. WILLIAMS					22e. ADDRESS MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-31-1986		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD						
24. FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, MD 21502					25a. DATE RECEIVED BY REGISTRAR DEC 31 1986							25b. REGISTRAR'S SIGNATURE Julia Anderson-Roads	

BP

DHMH-16 60M 7/84
(VFA) (5, 4)

20% COTTON FIBER

029255 JAN 5 1987

FOR STATE REGISTRAR
 DUST FUNERAL HOME
 57 FROST AVENUE
 FROSTBURG, MD 21532

STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

8 6 3 3 3 6 /

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE VIRGINIA LAST DAVIS			2a. DATE OF DEATH MONTH 12 DAY 24 YEAR 86		2b. HOUR 11:20 pm
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH 11 DAY 18 YEAR 24		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.	
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MARYLAND			13b. COUNTY ALLEGANY	13c. CITY OR TOWN CUMBERLAND	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST BERNARD MIDDLE CLISE LAST			15. MOTHER'S MAIDEN NAME FIRST NELLIE MIDDLE HUGHES LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-22-6206		17. INFORMANT ADDRESS JOSEPH DAVIS, LONACONING, MD. 21539	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Thomas Carbow for</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. GARY L. WAGONER M.D.		22e. ADDRESS 925 BISHOP WALSH RD. CUMBERLAND, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE DEC. 27, 86	23c. NAME OF CEMETERY OR CREMATORY ROCKY GAP VET CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE CUMBERLAND, MD.	
24. FUNERAL DIRECTOR NAME DUST FUNERAL HOME, FROSTBURG, MD.		ADDRESS		25a. DATE REC'D. BY REGISTRAR DEC 31 1986	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must immediately be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. This certificate should be filed with the health officer's office with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

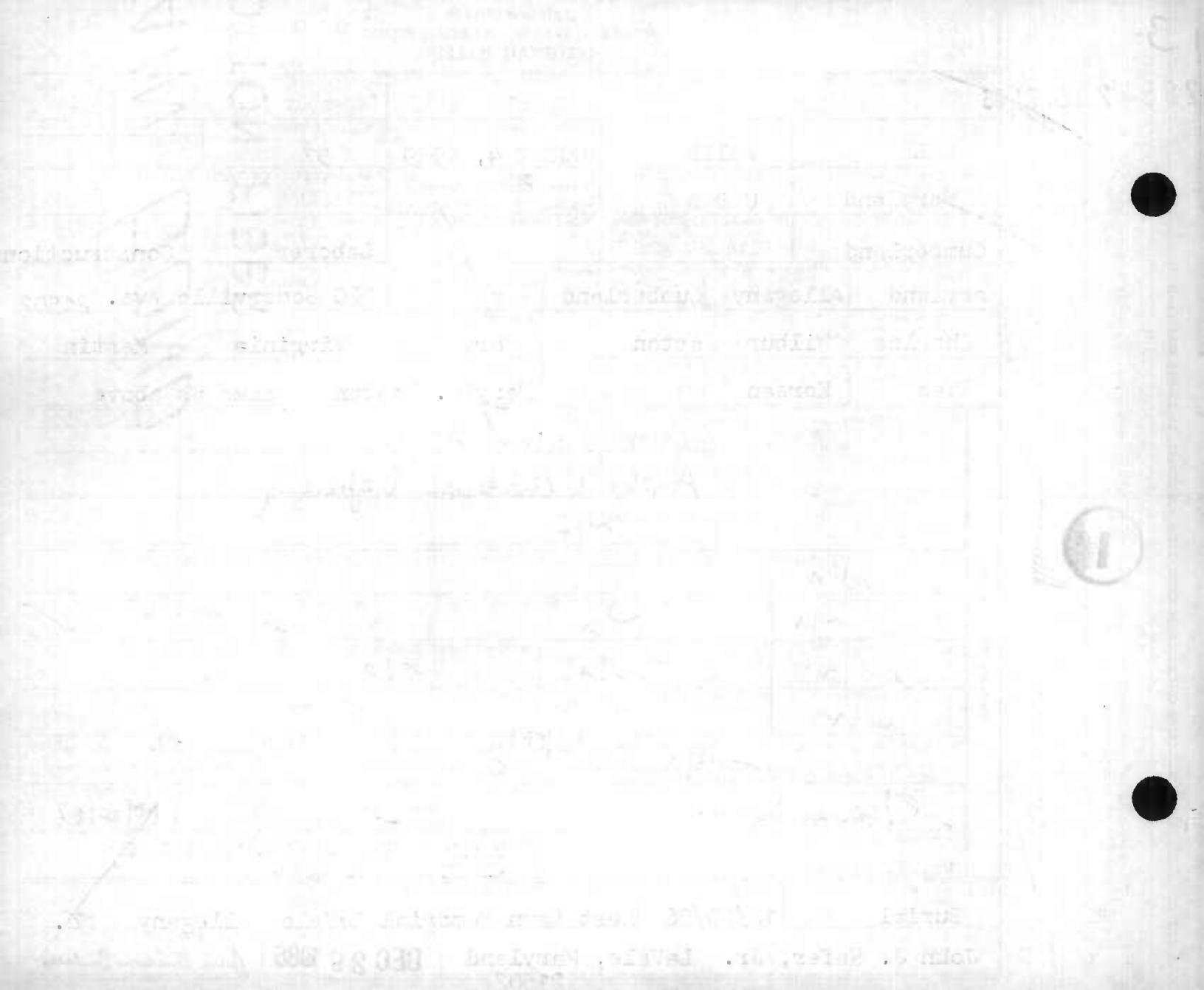
BP _____

U. S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535
MEMORANDUM FOR THE DIRECTOR
SUBJECT: [Illegible]
DATE: [Illegible]
FROM: [Illegible]
TO: [Illegible]

Respectfully,

Thomas J. [Illegible]

ENCLOSURE
100-277503-100
DEC 8 1960
FBI - [Illegible]



FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME FIRST MIDDLE LAST ROBERT DONALD EBERSOLE			2a. DATE OF DEATH MONTH DAY YEAR December 10, 1986		2b. HOUR 5:55 P_M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 20 23		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 63 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital & Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY Freight	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Pa.		13b. COUNTY Bedford		13c. CITY OR TOWN RD #4 Bedford		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Edward Henry Ebersole		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Reighard		13e. STREET ADDRESS / ZIP CODE RD #4 Box 169 Bedford 15522			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 300-18-7918		17. INFORMANT ADDRESS Mrs. Mary Ebersole RD #4 Bedford, Pa. 15522			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Malignant Melanoma DUE TO, OR AS A CONSEQUENCE OF (c) 5 Months Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>S. Gupta</i>		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/10/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. S. Gupta		22e. ADDRESS 69 Greene Street Cumberland, MD 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-13-86		23c. NAME OF CEMETERY OR CREMATORY Bedford Co. Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Bedford Bedford Pa.	
24. FUNERAL DIRECTOR NAME Timothy A. Berkebile		ADDRESS 214 S. Juliana St		25a. DATE REC'D. BY REGISTRAR DEC 15 1986		25b. REGISTRAR'S SIGNATURE <i>Lia Tardem-Randee</i>	

027821 122100Z

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
[The following text is extremely faint and largely illegible, appearing to be a series of lines or a list.]

Eichhorn Funeral Home

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

8 6 3 3 3 7 0

1. FOR STATE REGISTRAR Main Street
Lonaconing MD 21539

REG. NO.

1. DECEASED NAME FIRST MIDDLE LAST Raymond G. Eichhorn			2a. DATE OF DEATH MONTH DAY YEAR December 11, 1986		2b. HOUR 1:28A M						
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 13, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS HOURS MIN.	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		9b. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County, MD.					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY Plant			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md		13c. COUNTY Allegany		13d. CITY OR TOWN Frostburg		13e. STREET ADDRESS / ZIP CODE Rt 1, Box 548 21532					
14. FATHER'S NAME FIRST MIDDLE LAST Gustave Eichhorn				15. MOTHER'S MAIDEN NAME MIDDLE LAST Martha Atkinson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WWII		17. INFORMANT Inez Eichhorn		ADDRESS Md. Rt. 1, Box 548, Frostburg,					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Coronary atherosclerosis

DUE TO, OR AS A CONSEQUENCE OF

(b) Coronary Artery Disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Susan Schwartz</i>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/11/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Susan Schwartz, M.D.				22e. ADDRESS Frostburg Plaza, Frostburg, MD 21532			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-15-86		23c. NAME OF CEMETERY OR CREMATORY Rocky Gap Vet. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany Md.			
24. FUNERAL DIRECTOR Lonaconing, Md. 21539 Eichhorn-McKenzie Funeral Home				25a. DATE REC'D. BY REGISTRAR DEC 17 1986				25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and file pages 1 and 2 within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, there is any injury, or other traumatic event, a medical examiner must be notified at once.

1. FOR STATE REGISTRAR		SCARPELLI FUNERAL HOME		STATE OF MARYLAND		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		86 33371	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR	
ARTHUR NEWTON ELKINS								DECEMBER 18, 86	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		2b. HOUR	
male		white		08-26-1908		78 YRS.		2:55P _M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
WV		USA				ALLEGANY COUNTY		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Cumberland		SACRED HEART HOSPITAL		retired		Bd of Education			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
MD		Allegany		Cumberland		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Route 8 - Valley Road/21502	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Joseph H. Elkins		Mary Ann Gay							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					
No		217-10-4169		Mrs. Alice Elkins, Cumberland, MD 21502					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		Cerebrovascular accident						W/	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		COPD, CVA							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/16 to 12/18 1986, that (I) (we) last saw the deceased alive on 12/18 1986, and that in (my) best opinion death occurred on the date and hour and from the causes stated above. (I) would not view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						12/21/86			
BMG									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		12-21-1986		Sunset Memorial Park		Cumberland Allegany MD			
24. FUNERAL DIRECTOR NAME		456 29 1986		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
James F. Scarpelli, Cumberland, MD 21502						Julia Dandora-Kendall			

33371

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE

100-33371

RECEIVED NOV 22 1957
FBI
WASHINGTON

ALBANY COUNTY

SACRED HEART HOSPITAL

11-10-57



ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 3-2-82 BY 33371

29256 JAN -5

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Franklin L. Fatkin Sr.			2a. DATE OF DEATH MONTH DAY YEAR December 29, 1986		2b. HOUR 4:30 P
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 9, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH Frostburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 1, Box 601		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Textile		12b. KIND OF BUSINESS OR INDUSTRY Celanese
13a. STATE Maryland			13b. COUNTY Allegany	13c. CITY OR TOWN Frostburg	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Fatkin			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Arella Blubaugh		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W. W. 2 218-12-5435		17. INFORMANT ADDRESS Ruth R. Fatkin, Same as 13c	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) massive stroke DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 8 for 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Dr. R. Espina				22c. DATE SIGNED 12/30/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. R. Espina for Dr. V.R. Felipa				22e. ADDRESS 907 Seton Dr., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Jan. 1 '87	23c. NAME OF CEMETERY OR CREMATORY Vale Summit Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Vale Summit, Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Durst Funeral Home, Frostburg, Md.				25a. DATE REC'D. BY REGISTRAR DEC 31 1986	
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Penderson	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP _____

027361 DEC 17 86

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 3 3 7 3

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PEARL F. FILER			2a. DATE OF DEATH MONTH DAY YEAR 12-9-86		2b. HOUR 2:30 M		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 7 14 02		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CUMBERLAND NURSING CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEMAKER		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) IN STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN FROSTBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS FATKIN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE MCFARLAND		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-74-8183	
17. INFORMANT EVELYN FILER		18. ADDRESS RT. 3, BOX 106 FROSTBURG, MD.		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 YRS.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **MASSIVE CORONARY OCCLUSION**Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.(b) **ARTERIOSCLEROTIC CV DISEASE**

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

NONE

19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) NONE			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) NONE		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 48 BROADWAY - FROSTBURG - MD. 21532			
22a. I certify that (I) (this hospital) attended the deceased from JUNE 12-09 1986 to 12-09 1986 , that (I) (we) lost saw the deceased alive on 12-09 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.							
22b. SIGNATURE Martin M. Rothstein M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/10/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN M. ROTHSTEIN M.D.		22e. ADDRESS 48 BROADWAY - FROSTBURG - MD. 21532					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC 12, 1986		23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE FROSTBURG, MD.	
24. FUNERAL DIRECTOR NAME DUKST FUNERAL HOME		ADDRESS FROSTBURG, MD.		25a. DATE REC'D. BY REGISTRAR DEC 16 1986		25b. REGISTRAR'S SIGNATURE [Signature]	

027371 DEC 17 28

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
[The following text is extremely faint and largely illegible, appearing to be a memorandum or letter. It contains several lines of text, some of which may be dates or references, but they cannot be accurately transcribed.]



028324 DEC 22 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please use the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 8, the medical examiner must be notified immediately.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 6 3 3 3 7 4	
1- FOR STATE REGISTRAR				CERTIFICATE OF DEATH	
1. DECEASED NAME (LAST OR PRINT)				REG. NO.	
HARRY WILLIAM FISHER				2a. DATE OF DEATH MONTH DAY YEAR 12 17 86 1954P M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 03 20 15	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY ALLEGANY 13c. CITY OR TOWN FLINTSTONE 13d. INSIDE CITY LIMITS? YES X NO				12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED MARTON THIKOL CORP. 12c. KIND OF BUSINESS OR INDUSTRY	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES H. FISHER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AMANDA HERRICK	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW11 214-07-3618		17. INFORMANT ADDRESS I. MYRTLE FISHER RFD# 1 BOX# 190 FLINTSTONE, MARYLAND 21530	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Cordiac arrest					
DUE TO, OR AS A CONSEQUENCE OF (b) Ventricular fibrillation					
DUE TO, OR AS A CONSEQUENCE OF (c) XSCVD					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a. Congestive heart failure + CHF					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES NO X	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED AT WORK NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12-17, 1986, to 12-17, 1986, that (we) last saw the deceased alive on 12-17, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE [Signature]		DEGREE M.D. ATTENDING PHYSICIAN MEDICAL DIRECTOR STAFF PHYSICIAN		22c. DATE SIGNED 18 Dec 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. ANTHONY BOLLINO				22e. ADDRESS MEMORIAL HOSPITAL CUMBERLAND MD.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC 20 1986		23c. NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL PARK	
23d. LOCATION CITY OR TOWN COUNTY STATE CUMBERLAND ALLEGANY MARYLAND		24. FUNERAL DIRECTOR NAME ADDRESS SILCOX-MERRITT FUNERAL HOME CUMBERLAND MARYLAND			
25a. DATE REC'D. BY REGISTRAR DEC 22 1986				25b. REGISTRAR'S SIGNATURE [Signature]	

026612 DEC

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT (PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST Walter			MIDDLE Jacob			LAST Franklin			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR Dec. 2, 1986			2b. HOUR 1708				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10-3-913		6. AGE (IN YEARS) (LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Dec. 2, 1986			2d. HOUR 1708				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Canada				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Allegany							
10. CITY OR TOWN OF DEATH CUMBERLAND				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired				12b. KIND OF BUSINESS OR INDUSTRY General Motors			
13a. STATE Maryland				13b. COUNTY ALLEGANY				13c. CITY OR TOWN CUMBERLAND				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS Road *1108 Braddock Street 21502			
14. FATHER'S NAME FIRST MIDDLE LAST Isaac Franklin								15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah nm											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				(IF YES, GIVE WAR OR DATES) War II				16b. SOCIAL SECURITY NO. 066180815				17. INFORMANT ADDRESS Mr. Simon B. Franklin, Cumberland, Md. Son							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																			
(b) CORONARY ARTERY DISEASE																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE Giovanni Mastrangelo						TITLE (SPECIFY) Deputy						DATE SIGNED 12-2-86							
EXAMINER'S NAME (TYPE OR PRINT) Giovanni Mastrangelo, M.D.						ADDRESS 900 Seton Drive, Cumberland, Md. 21502													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE 12-5-1986		23c. NAME OF CEMETERY OR CREMATORY Rocky Gap VA Cemetery						23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.					
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md. 21502												25a. DATE REC'D. BY REGISTRAR DEC 05 1986			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall				

07/84
25M

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028922 JAN

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT) FRANK NMI GAGLIAN				2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 25, 1986			
1. SEX Male				2b. HOUR 6:45P M			
4. RACE White				5. DATE OF BIRTH MONTH DAY YEAR Feb. 18, 1895			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy				6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.			
7b. CITIZEN OF WHAT COUNTRY? U.S.A.				9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.			
10. CITY OR TOWN OF DEATH Cumberland				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital			
12a. USUAL OCCUPATION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Self Employed				12b. KIND OF BUSINESS OR INDUSTRY Glass			
13a. STATE Maryland				13b. COUNTY Allegany			
13c. CITY OR TOWN LaVale				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME Liborio Gaglian				15. MOTHER'S MAIDEN NAME Josephine Papple			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 214056499			
17. INFORMANT Betty Fazenbaker-Rt. 2, Box 227-F 26753				ADDRESS Ridgeley, W. Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Thomas W. Bore		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GARY WAGONER		22e. ADDRESS 925 BISHOP WALSH ROAD, CUMBERLAND, MD 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 28, 1986		23c. NAME OF CEMETERY OR CREMATORY Hillcrest		23d. LOCATION Cumberland COUNTY STATE	
24. FUNERAL DIRECTOR John J. Hafer, Jr LAvale Md.				25a. DATE REC'D. BY REGISTRAR DEC 30 1986			
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

29447 JAN -87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) RACHEL HELENA GARNER			2a. DATE OF DEATH MONTH DAY YEAR December 30, 1986		2b. HOUR 5:30 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 9, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Loibel		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-20-5434		17. INFORMANT ADDRESS Louis c. Garner same as 13a-e.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) RIGHT LOWER LOBE PNEUMONIA

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

4 DAYS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from 12-24, 19-86, to 12-30, 19-86, that (1) (we) lost saw the deceased alive on 12-29, 19-86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)					
22b. SIGNATURE William Lamm MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/30/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. W. Lamm		22e. ADDRESS Memorial Hospital Medical Building Cumberland, MD 21502			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1/3/87	23c. NAME OF CEMETERY OR CREMATORY Rest Lawn Mem. Park LaVale Allegany MD	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME Leasure-Stein Funeral Home, Inc.		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 5 1987 Jane Davidson-Randall	
230 Baltimore Ave. Cumberland, Maryland			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows injury or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

LEASURE-STEIN FUNERAL HOME				STATE OF MARYLAND			
1. FOR STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE			
230 BALT. ST. CUMBERLAND, MD				8 6 3 3 3 7 8			
CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
BRUCE Elaine GATES SR.				DECEMBER 6, 1986		1:50P M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR IF UNDER 24 HRS	
Male	Negro	Sept. 16, 1928		58 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland	U.S.A.			ALLEGANY COUNTY MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland	SACRED HEART HOSPITAL						
13a. STATE				13b. COUNTY		13c. CITY OR TOWN	
Maryland				Allegany		Cumberland	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Lawrence J. Gates				Sylvia V. Stephens			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Yes		1951-53		Roberta E. Gates same as 13 a-e.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Disseminated Adenocarcinoma</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) _____							
DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Hepatorenal syndrome, Hypercalcemia due to metastases</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
Paul Flink M.D.						12/6/91	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
PAUL FLINK, M.D.		912 SETON DRIVE CUMBERLAND, MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		12/9/86		Sunset Memorial Park		Cumberland Allegany MD	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE					
Leasure-Stein Funeral Home, Inc.		DEC 9 1986					
230 Baltimore Ave. Cumberland, MD 21502							

020706 100 14-05

LEAFLET FROM FURNACE
250 BALT. ST. CLARKSON, N.Y.
1950

DECEMBER 5, 1955

STATE OF NEW YORK
COUNTY OF ALLEGANY

ALLEGANY COUNTY

CLARKSON HOSPITAL

CLARKSON



210 SEVEN FIVE CLARKSON, N.Y. 15005

CLARKSON, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card from pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 6 3 3 3 7 9	
SCARPELLI FUNERAL HOME 108 VIRGINIA AVE. CUMBERLAND, MARYLAND 21502 GLADYS LAVADA GRAY		CERTIFICATE OF DEATH REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) CUMBERLAND, MARYLAND 21502		2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 26, 1986	
3. SEX female		4. RACE white	
5. DATE OF BIRTH MONTH DAY YEAR 08-28-1913		6. AGE (IN YEARS LAST BIRTHDAY) 73	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD		13b. COUNTY Allegany	
13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 227 Harrison Street/21502			
14. FATHER'S NAME FIRST MIDDLE LAST J.W. Pauley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lenna Pauley	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 579160386	
17. INFORMANT ADDRESS Mrs. Darlene Mutchner, Cumberland, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) END STAGE CHRONIC OBSTRUCTIVE PULMONARY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ARTERIO SCLEROTIC HEART DISEASE, CONGESTIVE HEART FAILURE, CARDIAC ARRHYTHMIA			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from DEC 22 , 19 86 , to Dec. 26 , 19 86 , that (I) (we) lost saw the deceased alive on Dec. 26 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE S. Chang		22c. DATE SIGNED 12/28/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SATURNINA CHANG		22e. ADDRESS FROSTBURG PLAZA; FROSTBURG, MD 21532	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-29-1986	
23c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Arlington VA	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502		25. DATE REC'D. BY REGISTRAR DEC 31 1986	
25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodarte			

DECEMBER 1968

DECEMBER 1968

ALTERNATE

DECEMBER 1968



DECEMBER 1968

DECEMBER 1968

29450 JAN -68

BOAL'S FURNACE

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 3 3 8 0

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LEDA FLORENCE GREEN			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 31, 1986		2b. HOUR 5:55 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 23 1894		
6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.		10. CITY OR TOWN OF DEATH Cumberland				
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		
12b. KIND OF BUSINESS OR INDUSTRY House				13a. STREET ADDRESS / ZIP CODE Box 46 Rt 36 21539		
13b. STATE Maryland		13c. COUNTY Allegany		13d. CITY OR TOWN Lonaconing		
13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS / ZIP CODE Box 46 Rt 36 21539				
14. FATHER'S NAME FIRST MIDDLE LAST George Andrews		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Jane Shaw				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 220 03 7936D		17. INFORMANT ADDRESS Mrs. Mildred James Lonaconing, Md. 21539		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) Chronic heart infection & reperis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 minute
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19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12/30 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 12/31 1986			
22a. I certify that (I) (this hospital) attended the deceased from 12/31 1986 to 12/31 1986 , that (I) (we) last saw the deceased alive on 12/31 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE R Espina MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/31/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RENATO ESPINA, MD		22e. ADDRESS 907 SETON DRIVE, CUMBERLAND, MD 21502					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/3/87		23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Barton Allegany Maryland	
24. FUNERAL DIRECTOR NAME Boal Funeral Service ADDRESS Lonaconing, Md. 21539				25a. DATE REC'D. BY REGISTRAR JAN 5 1987		25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Scarpelli Funeral Home 108 Virginia Avenue Cumberland, Md. 21502				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 6 3 3 3 8 1			
FOR STATE REGISTRAR				REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) Charles Henry Gross				2a. DATE OF DEATH MONTH DAY YEAR December 28, 1986				2b. HOUR 02:40 AM			
3 SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 01-29-1926		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD.					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none		12b. KIND OF BUSINESS OR INDUSTRY disabled			
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10 Humbird Street/21502			
14. FATHER'S NAME FIRST MIDDLE LAST Humbird C. Gross				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie M. Roby							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WW II 216-22-6190		17. INFORMANT ADDRESS Mrs. Mary Wilburn, Mt. Savage, MD - sister					
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ventricular arrhythmias</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ischem</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Coronary artery transposition p. V. fib on admission! ASCVD</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <u>12/26</u> , 19 <u>86</u> , to <u>12/28</u> , 19 <u>86</u> , that (1) (we) lost <u>12/27</u> , 19 <u>86</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) (did) (and not) view the body after death.											
22b. SIGNATURE <u>Dr. Anthony Bollino</u>				DEGREE <u>M.D.</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>28 Dec 86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Anthony Bollino				22e. ADDRESS 955 Frederick Street, Cumberland, Md. 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-31-1986		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD					
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502				25. DATE REC'D. BY REGISTRAR <u>DEC 31 1986</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Rodgers</u>					

20% CILION FIBER



026708 DEC 11

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BOALS FUNERAL HOME

STATE OF MARYLAND

FOR 111 CHURCH STREET
STATE REGISTRAR WESTERNPORT, MD 21562DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 3 3 8 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET MANN GROVE			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 7, 1986		2b. HOUR 10:00P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 11 1901		
6. AGE (IN YEARS LAST BIRTHDAY) 85		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD.						
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		
12b. KIND OF BUSINESS OR INDUSTRY House						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN W. Va. Mineral Keyser						
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
13e. STREET ADDRESS / ZIP CODE Rt. 4 Box 31 26743 9999						
14. FATHER'S NAME FIRST MIDDLE LAST David Mann			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Christine Frew			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 220165728		17. INFORMANT ADDRESS Mrs. John Smith Keyser, W. Va. 26726		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 887 IMMEDIATE CAUSE (a) Coronary Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 21 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a Arteriosclerosis, Hip fracture, Cancer colon						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE George Drey MD		DEGREE MD		22c. DATE SIGNED 12/9/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS BMG, 912 SETON DRIVE, CUMBERLAND, MD 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12 10 86		23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		
23d. LOCATION (CITY OR TOWN) (COUNTY) (STATE) Barton Allegany Maryland						
24. FUNERAL DIRECTOR NAME ADDRESS Boals Funeral Service Westernport, Md. 21562		25a. DATE REC'D. BY REGISTRAR DEC 10 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Randall		

02870 DEC 11 82

WILLIAM STREET
NORTHAMPTON, ND 21502

DECEMBER 7, 1982

MARGARET
MAYNARD

Female
Age 41 1901

Married
X

General
GEOGRAPHIC

1000
X

David
1000

1000

1000

1000

1000

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1000

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1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 6 3 3 3 8 3			
REG. NO.				REG. NO.				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
Bertha M. Harden				12-26-86				5:05P _M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
female		white		05-29-1896		90 YRS		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
VA		USA				Allegany MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Westernport		Moran Manor		housewife		own home					
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			
MD				Allegany		LaVale		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Jacob Kerns				Margaret Amick							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
no				214-07-6799		Donna M. DeFries, LaVale, MD - daughter					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <u>Cardiorespiratory Failure</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Septicemia</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary artery disease</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
Dr. Jesus Tan, M.D.				Frostburg Plaza, Frostburg, MD 21532							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE	
Burial		12-29-1986		Sunset Memorial Park		Cumberland		Allegany		MD	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
NAME ADDRESS											
James F. Scarpelli, Cumberland, MD 21502				DEC 31 1986		Julia T. Scarpelli					

BP

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028148 DEC 20 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST LEONA ROSELIA HARPER			MONTH DAY YEAR DECEMBER 17 1986			8:20 P.M.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
FEMALE	WHITE	MONTH DAY YEAR JANUARY 4 1902	84 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						
MARYLAND	USA	ALLEGANY MD.						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND	1300 BEDFORD STREET		FORMER EMP. DEPT. STORE			STORE		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
MARYLAND	ALLEGANY	CUMBERLAND	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			135 NORTH MECHANIC STREET		
14. FATHER'S NAME FIRST MIDDLE LAST JOHN DIGGS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE HAMMERSMITH					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
NO			213-22-4371			CHARLES HARPER JR 1300 BEDFORD ST CUMBERLAND		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immed.
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								Immed.
(b) Sudden Arrhythmia; Auricular/ Ventricular Left Bundle Branch Block								Immed.
(c) Coronary Arteriosclerosis, Myocardial Fibrosis								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Surgery for ruptured appendix left side with peritonitis								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
9/20/86			Ruptured appendicitis left side			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 3/9/49 , 19____, to 12/17/86 , 19____, that (I) (we) last saw the deceased alive on 12/14/ 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) saw the body after death.								
22b. SIGNATURE <i>Samuel M. Jacobson</i>						DEGREE MD		22c. DATE SIGNED 12/19/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. SAMUEL M. JACOBSON						22e. ADDRESS 50 PERSHING STREET CUMBERLAND MARYLAND 21502		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 20 DEC 1986			23c. NAME OF CEMETERY OR CREMATORY ST MARY'S CEMETERY		
						23d. LOCATION CITY OR TOWN COUNTY STATE CUMBERLAND ALLEGANY MARYLAND		
24. FUNERAL DIRECTOR NAME ADDRESS SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MARYLAND						25a. DATE REC'D. BY REGISTRAR DEC 23 1986		25b. REGISTRAR'S SIGNATURE <i>Julia L. Davidson</i>

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic, or physical cause of death, a medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove captioned pages. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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026156 DEC

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked as item 18 shows only injury, or other traumatic event, the medical examiner must be notified by phone.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RETA VIRGINIA HARTLEY						2a. DATE OF DEATH MONTH DAY YEAR December 1, 1986			2b. HOUR 9:12 P.M.		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JUNE 2 1921		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA.		10. CITIZEN OF WHAT COUNTRY? USA		11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		12. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.					
13. CITY OR TOWN OF DEATH Cumberland		14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE			16. KIND OF BUSINESS OR INDUSTRY -----		
17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 17a. STATE PENNA.		17b. COUNTY BEDFORD		17c. CITY OR TOWN ARTEMAS		17d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		17e. STREET ADDRESS / ZIP CODE RFD# 1 BOX# 125 99999			
18. FATHER'S NAME FIRST MIDDLE LAST GEORGE WASHINGTON POOLE				19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LULA MYRTLE ELBIN							
20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		21. SOCIAL SECURITY NO. 12-72-4352		22. INFORMANT ADDRESS RICHARD HARTLEY RFD# 1 ARTEMAS PA. 17211							
23. CAUSE OF DEATH (Enter only one cause per line for terminal disease or condition) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO, OR AS A RESULT OF, OR COMPLICATED BY (b) DUE TO, OR AS A RESULT OF, OR COMPLICATED BY (c) Cardiopulmonary Arrest Acute Myocardial MI Ventricular Fibrillation, (CA) Doberman's Pulmonary Disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT FINDINGS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
24. DATE OF OPERATION		25. CONDITION FOR WHICH OPERATION WAS PERFORMED				26. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
28. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		29. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
31. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		32. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.)		33. LOCATION STREET TOWN COUNTY STATE							
34. I certify that (1) this hospital attended the deceased from Nov. 29 1986 to Dec 1 1986 that (1) (we) last saw the deceased alive on Dec 1 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (did) (did not) see the body after death.											
35. SIGNATURE Dr. T. Williams				36. DEGREE MD				37. ATTENDING PHYSICIAN MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		38. DATE SIGNED 12-2-86	
39. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. T. Williams				40. ADDRESS Memorial Hospital Med. Bldg., Cumberland, MD 21502							
41. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		42. DATE DEC 4 1986		43. NAME OF CEMETERY OR CREMATORY FAIRVIEW CHRISTIAN CEM.				44. LOCATION INGLESBETH BEDFORD PA. STATE			
45. FUNERAL DIRECTOR SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MARYLAND				46. DATE REC'D. BY REGISTRAR DEC 3 1986		47. REGISTRAR'S SIGNATURE Julia Davidson-Roadner					

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(VRA 15.4)

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please enter the burial papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR					
GEORGE		JOHN		HEINRICH				DECEMBER 22 1986								2:08 P.M.					
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)				7. IF UNDER 1 YEAR				IF UNDER 24 HRS.					
Male		White		Oct. 21, 1914				72 YRS.				MONTHS				DAYS					
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH											
Maryland		U.S.A.								ALLEGANY COUNTY MD.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY											
Cumberland		SACRED HEART HOSPITAL				Kelly-Springfield Tire Company															
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE													
Maryland		Allegany		Cumberland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		12216 Fall Ave., S.W. / 21502													
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																			
George		Heinrich		Frances		Schultz															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS																	
No		217-10-7479		Mildred Heinrich-Address same as #13 above.																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY:																					
IMMEDIATE CAUSE (a) Pneumonia																					
DUE TO, OR AS A CONSEQUENCE OF																					
(b) Clostric encephalopathy																					
DUE TO, OR AS A CONSEQUENCE OF																					
(c) Cardiac arrest (M.I.)																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?													
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																	
		HOUR A.M. MONTH DAY YEAR																			
		P.M. 19																			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION																	
				STREET				CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from Nov. 1986, to Dec. 22, 1986, that (I) (we) lost saw the deceased alive on Dec. 22, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED											
Uriel Velandia										12-23-86											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS																			
URIEL VELANDIA, MD		924 SETON DRIVE, CUMBERLAND, MD 21502																			
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION													
Burial		12-16-86		Sunset Memorial Park				CITY OR TOWN COUNTY STATE													
								Cumberland-Allegany-Maryland													
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE															
George-Upchurch Funeral Home, P.A.		DEC 30 1986				Julia Davidson-Randall															
202 Greene Street-Cumberland, MD 21502																					

029631 JAN 16 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

3 3 3 8 1

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Daphne Virginia Hout			2a. DATE OF DEATH MONTH DAY YEAR 12-28-1986		2b. HOUR 12:38 M
3 SEX female	4 RACE white	5. DATE OF BIRTH MONTH DAY YEAR 08-14-1914		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital (DOA)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife	12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. STATE MD		13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 568 Cromwell Terrace/21502
14. FATHER'S NAME FIRST MIDDLE LAST Charles H. Plummer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Wade			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-54-2062		17. INFORMANT ADDRESS Mrs. Charlene J. Burt, Rawlings, MD-daughter	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>asystole</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>As central vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ischemic heart disease</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/15</u> 19 <u>86</u> to <u>12/15</u> 19 <u>86</u> that (I) (we) last saw the deceased alive on <u>12/15</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Thaddeus H. Elder</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/29/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Thaddeus H. Elder, M.D.		22e. ADDRESS Memorial Hospital Medical Bldg, Cumberland, MD			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12-31-1986	23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502		25a. DATE RECEIVED BY REGISTRAR JAN 12 1987	
		25b. REGISTRAR'S SIGNATURE <u>Julia D. Anderson-Rudace</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
 TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

EX-100-4185



100-4185-100

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 3 3 8 8
REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. LEAVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH ITEM 1B. J. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT (PAGE 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)		JESSE		FRANKLIN		JACOBS		2a. DATE KNOWN OF DEATH		X MONTH 12/5 DAY 19 YEAR 86		7b. HOUR 4:30 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7c. DATE PRONOUNCED DEAD		12/5/86		7d. HOUR 4:30 AM	
MALE		WHITE		6/13/05		81 YRS.		DEAD					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		X NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		ALLEGANY		MD	
MARYLAND		U.S.A.		WIDOWED		DIVORCED							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
FROSTBURG		98 W. COLLEGE AVENUE		FIRE MARSHALL		STATE							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		21532			
MARYLAND		ALLEGANY		FROSTBURG		YES X NO		98 W. COLLEGE AVE.					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		FROSTBURG, MD 21532			
STANLEY		OLIVE		NO		213-05-7153		MRS. JESSE JACOBS		98 W. COLLEGE AVE			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		FROSTBURG, MD 21532			
STANLEY		OLIVE		NO		213-05-7153		MRS. JESSE JACOBS		98 W. COLLEGE AVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Possible Multiple Myeloma DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?	
												YES NO X	
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
				P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes Accident Suicide Homicide Undetermined manner													
Autopsy Inspection Inquiry and in my opinion													
TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 12/5/86													
ACTUAL SIGNATURE Giovanni Mastrangelo ADDRESS 900 Seton Drive, Cumberland, Md.													
EXAMINER'S NAME (TYPE OR PRINT)													
23a. BURIAL, CREMATION, REMOVAL				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL				12/7/86				FROSTBURG MEM PARK				FROSTBURG ALLEGANY MD	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
SOWERS FUNERAL HOME FROSTBURG				DEC 9 1986				Julia Davidson-Rodden					

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GEORGE-UPCHURCH FUNERAL HOME STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM JAMES KELLER			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 8, 1986		2b. HOUR 11:00^A_M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 17, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist		12b. KIND OF BUSINESS OR INDUSTRY Celanese
13a. STATE Maryland		13b. CITY OR TOWN Frostburg		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE Rt. 3 Box 324 21532
14. FATHER'S NAME FIRST MIDDLE LAST Clyde Keller			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beulah Trexler			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214074198		17. INFORMANT ADDRESS Dolores Vogel P.O. Box 257 Intercourse, PA 17534		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral bleeding & Subdural Hematoma DUE TO, OR AS A CONSEQUENCE OF (b) Acute Renal Failure DUE TO, OR AS A CONSEQUENCE OF (c) Hypotension 2° sepsis & Subendocardial M.I. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) CNF, COPD						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 12-8 , 19 86 , to 12-8 , 19 86 , that (I) (we) lost saw the deceased alive on 12-8 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE B. Mahal		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-9-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BALJEET MAHAL, M.D.			22e. ADDRESS 909-B SETON DRIVE CUMBERLAND, MD. 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12-11-86		23c. NAME OF CEMETERY OR CREMATORY Rosedale Fun'l. Chapel		23d. LOCATION CITY OR TOWN COUNTY STATE Martinsburg Berkeley WV
24. FUNERAL DIRECTOR NAME George-Upchurch Fun'l. Home			24b. ADDRESS 202 Greene St. Cumb., MD 21502		25a. DATE REC'D. BY REGISTRAR DEC 17 1986	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be kept within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 3 0 9 0

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WILLIAM MARION KREGER			2a. DATE OF DEATH MONTH DAY YEAR December 6, 1986		2b. 7:48 AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAY 9 1911		
6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA.		8. MARried <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.		10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED RAILROAD		12b. KIND OF BUSINESS OR INDUSTRY ENGINEER		13a. STREET ADDRESS / ZIP CODE 308 NORTH WAVERLY TERRACE 21502		
13b. CITY OR TOWN CUMBERLAND		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 308 NORTH WAVERLY TERRACE 21502		
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL B. KREGER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FRANCIS ELIZABETH LINGENFELD		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		
16b. SOCIAL SECURITY NO. 705-10-4966		17. INFORMANT WILLIAM S. KREGER		17a. ADDRESS 23 N. WAVERLY TERRACE 21502		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Pericarditis DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Chronic Renal failure, Hx. Ca of Colon, Hx. Aortic aneurysm resection						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Ranjithan		DEGREE MD		22c. DATE SIGNED 12/8/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Ranjithan		22e. ADDRESS Med. Bldg., Cumberland Memorial Hosp & Med. Cnt Memorial Ave., Cumberland MD 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC 8 1986		23c. NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL PARK		
23d. LOCATION CITY OR TOWN COUNTY STATE CUMBERLAND ALLEGANY MARYLAND		24. FUNERAL DIRECTOR NAME ADDRESS SILCOX-MERRITT FUNERAL HOME CUMBERLAND MARYLAND				
25a. DATE REG'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE DEC 10 1986				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the necessary permit, then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BOALS FUNERAL HOME 111 CHURCH ST. WESTERNPORT, MD.				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE			
1. FOR STATE REGISTRAR				2. CERTIFICATE OF DEATH			
1. DECEASED NAME				2a. DATE OF DEATH			
FIRST MIDDLE LAST				MONTH DAY YEAR			
NOAH WILSON LEASE				DECEMBER 20, 1986			
2. SEX				3. RACE			
Male				White			
4. DATE OF BIRTH				5. AGE			
MONTH DAY YEAR				YEARS MONTHS DAYS HOURS MIN.			
2 24 1906				80			
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?			
West Virginia				USA			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
West Virginia				9. BALTIMORE CITY OR COUNTY OF DEATH			
Cumberland				ALLEGANY COUNTY MD.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			
Cumberland				SACRED HEART HOSPITAL			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Westvaco				Paper			
13a. STATE				13b. COUNTY			
Maryland				Allegany			
13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?			
Westernport				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST				FIRST MIDDLE LAST			
John W Lease				Sarah Lease			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.			
no				216070965			
17. INFORMANT				ADDRESS			
Mrs. Maude Lease				Westernport, Md 21562			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>myocardial infarction</u>							
DUE TO, OR AS A CONSEQUENCE OF (b)							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Asbestosis, Emphysema, arteriosclerosis</u>							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY			
				HOUR A.M. MONTH DAY YEAR			
				P.M. 19			
21d. INJURY OCCURRED				21e. PLACE OF INJURY			
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21f. LOCATION				CITY OR TOWN COUNTY STATE			
STREET							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE			
22c. DATE SIGNED				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
GEORGE BREZA, M.D.				BMG 912 SETON DRIVE CUMBERLAND, MD. 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE			
Burial				12/23/86			
23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
Mineral Baptist Cem.				CITY OR TOWN COUNTY STATE			
Port Ashby Mineral W.Va.							
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR			
NAME ADDRESS				25b. REGISTRAR'S SIGNATURE			
Boals Funeral Service Westernport, Md. 21562				DEC 29 1986			
				Julia Davidson-Randall			

BP

111 CHURCH ST. WESTPORT, N.Y.

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DECEMBER 30, 1903	LEASE	WILSON	1903	12	31	03
ALLEGANY COUNTY						
WESTPORT						
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.							
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
1. DECEASED NAME (LAST, FIRST, MIDDLE) MYRTLE BELLE LEASURE				December 14, 1986				10:40 AM			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 01-20-1908		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY own home			
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 313 Pennsylvania Avenue/21502			
14. FATHER'S NAME FIRST MIDDLE LAST Leroy Ammons				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Belle Toothman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-30-8284		17. INFORMANT ADDRESS Mr. George Wilson Gross, Cumberland, MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Persistent left Ventricular failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ischemic Cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Coronary Artery Disease, Diabetes, Anemia</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>[Signature]</i>		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/14/86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. N. Ranjithan		22e. ADDRESS Memorial Hospital Medical Bldg. Cumberland, MD 21502									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-17-1986		23c. NAME OF CEMETERY OR CREMATORY Mt. Herman Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD					
24. FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, MD 21502											

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Hafer Funeral Home

1302 National Hwy
LaVale, MD 21502DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Irma Virginia Lee			2a. DATE OF DEATH MONTH DAY YEAR December 25, 1986		2b. HOUR 23:41 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 4, 1921		
6a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna		6b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County, MD.		10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home		13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Allegany Cresaptown		
14. FATHER'S NAME FIRST MIDDLE LAST Edgar		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna Weimer		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		
17. SOCIAL SECURITY NO. 215-20-5864		18. INFORMANT ADDRESS Kenneth Lee- same as above				
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopalmory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ventricular Vent. fibr. arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>45 min.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from <u>12/25</u> , 19 <u>86</u> , to <u>12/25</u> , 19 <u>86</u> , that (1) (we) lost saw the deceased die on <u>12/25</u> , 19 <u>86</u> , and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Anthony Bollino</u>		DEGREE <u>M.D.</u>		22c. DATE SIGNED <u>12/25/86</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Anthony Bollino, M.D.		22e. ADDRESS 955 Frederick St., Cumberland, MD 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/28/86		23c. NAME OF CEMETERY OR CREMATORY Rest Lawn Mem. Gard		
23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany Md.		24. FUNERAL DIRECTOR John J. Hafer, Jr., LaVale, Md				
25a. DATE REC'D. BY REGISTRAR DEC 30 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove completed pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 33394

REG. NO.

1- FOR
STATE
REGISTRAR1. DECEASED NAME
(FIRST, MIDDLE, LAST)

FIRST

MIDDLE

LAST

Thelma

Lee

2a. DATE OF DEATH MONTH DAY YEAR

11/30/86

2b. HOUR

5:51p_M

3. SEX

female

4. RACE

white

5. DATE OF BIRTH

MONTH

DAY

YEAR

3

13

13

6. AGE (IN YEARS LAST BIRTHDAY)

73

IF UNDER 1 YEAR

IF UNDER 24 HRS.

MONTHS

DAYS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Allegany

MD.

10. CITY OR TOWN OF DEATH

Frostburg

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Frostburg Community Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Ordinance Plant

12b. KIND OF BUSINESS OR INDUSTRY

Laboratory

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

Maryland

13b. COUNTY

Allegany

13c. CITY OR TOWN

Cumberland

13d. INSIDE CITY LIMITS?

YES ☐NO ☒

13e. STREET ADDRESS / ZIP CODE

Brant Road 21502

14. FATHER'S NAME

John

MIDDLE

LAST

Cecil

15. MOTHER'S MAIDEN NAME

Susan

MIDDLE

LAST

McKenzie

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)

215-20-7325

17. INFORMANT

Janice Pope

ADDRESS

- Cresaptown, Md. 21502

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) Probable Acute Myocardial Infarction

DUE TO, OR AS A CONSEQUENCE OF

(c) AGING, Epilepsy

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

19c. AUTOPSY?

YES ☐ NO ☐

19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21a. INJURY OCCURRED

INJURY ☐ NOT INJURY ☐

21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21c. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did not) view the body after death.

19 84 to Nov 30 19 86, that (I) (we) last saw the deceased alive on Nov 30 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Dr. S. Kim

22e. ADDRESS

Main St., Westernport, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

12/04/86

23c. NAME OF CEMETERY OR CREMATORY

Hillcrest Burial Ph.

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

Cumberland Allegany MD

24. FUNERAL DIRECTOR

NAME

George-Upchurch Fun'l. Hm. Cumb., MD 21502

202 Greene St.

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

DEC 17 1986

Julia Davidson-Randall

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
LAWRENCE		C LEIDINGER		December 4, 1986		10:35 P. M.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
male	white	MONTH DAY YEAR 01-21-1910		76 YRS.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MD	USA			Allegany MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland	Memorial Hospital & Medical Center			retired		textile	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE			
MD	Allegany	Cumberland	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	28 Somerville Avenue/21502			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST		FIRST MIDDLE LAST					
George Leidinger		Sarah Rompf					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO		214-07-2067		Mrs. Margaret E. Leidinger, Cumberland, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Purified Cerebral</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Advanced Cerebral Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11:30</u> , 19 <u>86</u> , to <u>12:00</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>12-4</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
<u>William P. James</u>		MD		12/5/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
Dr. William P. James		441 N. Centre Street Cumberland, MD 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		12-8-1986		Davis Memorial Park		Cumberland Allegany MD	
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE			
Scarpelli Funeral Home, Cumberland, MD 21502				DEC 09 1986 <u>Julia Davidson-Randall</u>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please leave carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CECIL HENRY LEPLEY			2a. DATE OF DEATH MONTH DAY YEAR November 13, 1986		2b. HOUR 6:00p m
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 03/07/1912	6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor	12b. KIND OF BUSINESS OR INDUSTRY textile manuf.	
13a. STATE MD			13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Earl Lepley			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Delbrook		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 214-07-2809	17. INFORMANT ADDRESS Dorothy Lepley, 12 R Decatur, Cumberland, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septic shock. DUE TO, OR AS A CONSEQUENCE OF (b) Possible g-v sepsis. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Cardiogenic Shock, Ischemic Cardiomyopathy, Diabetes, Atherosclerosis, Renal Failure.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>[Signature]</i>		DEGREE MD		22c. DATE SIGNED 11/14/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. N. Ranjithan		22e. ADDRESS Memorial Hospital Medical Building Cumberland, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11/17/86	23c. NAME OF CEMETERY OR CREMATORY Restlawn Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE LaVale, Allegany, MD	
24. FUNERAL DIRECTOR NAME <i>[Signature]</i> ADDRESS Harvey H. Zeigler, Hyndman, PA 15545		25a. DATE REC'D. BY COUNTY CLERK 25b. REGISTRAR'S SIGNATURE NOV 18 1986 <i>[Signature]</i>			

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SHAFER FUNERAL HOME

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
OLLIE AMAZON LEWIS			DECEMBER 4, 1986			7:55 A.	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Female	White	July 27 1885	101 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
West Virginia	U.S.A.			ALLEGANY COUNTY MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland	SACRED HEART HOSPITAL		Housewife		Home		
13a. STATE			13b. CITY OR TOWN		13c. STREET ADDRESS / ZIP CODE		
WV	Mineral	Keyser	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt. 2, Box 192 26726		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
Jasper N. Carder			Alicinda Patterson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		235-60-3289		Helen Spencer, Rt. 2, Box 192, Keyser, WV			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>aspiration pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>cerebral vascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 days</u> <u>30 days</u>
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Anemia, azotemia, dehydration.</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>10/30</u> , 19 <u>86</u> , to <u>12/4</u> , 19 <u>86</u> , that (I) <u>(we)</u> lost saw the deceased alive on <u>12/5</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> (did not) view the body after death.							
22b. SIGNATURE <u>Paul Flink MD.</u>			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>12/5/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Paul Flink MD.</u>			22e. ADDRESS <u>BMG 912 SETON DRIVE, CUMBERLAND, MD 21502</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		12/6/86		Branch Mt. Cemetery		Three Churches Hampshire WV	
24. FUNERAL DIRECTOR NAME Keith S. Shaffer ADDRESS Shaffer Funeral Home, Inc., Romney, WV				25. DATE OF REGISTRATION BY REGISTRAR 26. REGISTRAR'S SIGNATURE <u>DEC 11 1986</u> <u>John A. [Signature]</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME FIRST MIDDLE LAST FRANCIS EDWARD LOIBEL			2a. DATE OF DEATH MONTH DAY YEAR November 30, 1986		2b. HOUR 4:20 P.M.				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 12 1918		6. AGE (IN YEARS LAST BIRTHDAY) 68		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital & Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Guard Force		12b. KIND OF BUSINESS OR INDUSTRY Factory	
13a. STATE Maryland			13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST John Joseph Loibel			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fredricka Cutter			13e. STREET ADDRESS / ZIP CODE 884 Sperry Terrace 21502			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Peggy Loibel Same as #13 above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Symptoms Cell CA lung - metastatic</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) <u>Resp. Unit</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>	
								PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>11-28</u> , 19 <u>86</u> , to <u>11-30</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>11-30</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Dr. J. Whitmore MD</i>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12-2-86</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. J. Whitmore					22e. ADDRESS 1068 National Highway LaVale, MD 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/03/86		23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD		
24. FUNERAL DIRECTOR NAME George-Upchurch Fun'l. HM. Cumb., MD 21502					25a. DATE REC'D. BY REGISTRAR DEC 17 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Gordon-Randall</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

03752 22750

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Their place remains with the funeral director. Pages 1 and 2 should be filed with the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 3 3 9 9

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ERMA VIRGINIA LOWERY			2a. DATE OF DEATH MONTH DAY YEAR December 3, 1986		2b. HOUR 8:45 P. M.	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 05-10-1914		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		12b. KIND OF BUSINESS OR INDUSTRY textile
13a. STATE MD			13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland	
14. FATHER'S NAME FIRST MIDDLE LAST Walter W. Weise			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Cage			13e. STREET ADDRESS / ZIP CODE 223 Cecelia Street/21502
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-07-3430		17. INFORMANT ADDRESS Mr. Joseph F. Lowery, Cumberland, MD - husband		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CAD - CHF</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASHD - Pulph V.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 0
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>11-24</u> , 19 <u>86</u> , to <u>12-3</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>12-3</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>John. Whitmore MD</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. John Whitmore				22e. ADDRESS P.O. Box 3175 LaVale, MD 21502		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-6-1986		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502				25. DATE RECEIVED BY REGISTRAR DEC 09 1986		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FEDERAL BUREAU OF INVESTIGATION STATE OF MARYLAND CAPON BRIDGE WV 26711				DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8633-00			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CLARICE ONEDA MCBRIDE				2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 10, 1986				2b. HOUR 8PM			
3 SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 11, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hampshire, West Va		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY Own home			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE West Va				13b. COUNTY Hampshire		13c. CITY OR TOWN Springfield		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13. STREET ADDRESS / ZIP CODE P.O. Box 60, 26763 99999	
14. FATHER'S NAME FIRST MIDDLE LAST Arthur C Malick				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna Eaton							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 234969249		17. INFORMANT ADDRESS Helen Haslacker, Springfield, WV							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ca of breast with widespread DUE TO, OR AS A CONSEQUENCE OF (c) metastases										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 10-17 , 19 86 , to 12-10 , 19 86 , that (I) (we) lost saw the deceased alive on 12-10 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE John Mehan				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-14-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN MEHANNA, M.D.				22e. ADDRESS 909-B SETON DRIVE, CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-13-1986		23c. NAME OF CEMETERY OR CREMATORY Malick Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Augusta, WV Hampshire WV			
24. FUNERAL DIRECTOR NAME Ray Giffin				ADDRESS Capon Bridge, WV				25a. DATE REC'D. BY REGISTRAR 12-10-1986			
25b. REGISTRAR'S SIGNATURE John Mehan											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 3 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body. The medical examiner must be notified at once. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN ALBERT MCCARTY			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 1, 1986		2b. HOUR 1:20A M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 22, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST John A. McCarty			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth Pierce				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --		17. INFORMANT ADDRESS Lorena McCarty same as 13a-e.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) HEPATIC FAILURE DUE TO HEPATIC CIRRHOSIS (CARCINOMA) DUE TO, OR AS A CONSEQUENCE OF (c) TERMINAL LIVER DISEASE (CARCINOMA) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
21g. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) see the body after death.							
22a. SIGNATURE <i>[Signature]</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) DR. TORRES				22d. ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MEDICAL BUILDING MARYLAND 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/4/86		23c. NAME OF CEMETERY OR CREMATORY Restlawn Mem Park		23d. LOCATION CITY OR TOWN COUNTY STATE LaVale Allegany MD	
24. FUNERAL DIRECTOR NAME Leasure-Stein Funeral Home, Inc.				25. DATE REC'D. BY REGISTRAR DEC 4 1986		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
230. Baltimore Ave. Cumberland, MD 21502							

BP _____

027500 DEC 17 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 3 4 0 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ROBERT SHERMAN MC COOLE			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 8, 1986			2b. HOUR 8:00A M			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 02-24-1919		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		12b. KIND OF BUSINESS OR INDUSTRY Post Office	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE WV		13b. COUNTY Mineral		13c. CITY OR TOWN Ridgeley		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE none/26753 99999	
14. FATHER'S NAME FIRST MIDDLE LAST Robert H. McCoolle				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Sherman McCoolle					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes				16b. SOCIAL SECURITY NO. WW II 233-16-6731		17. INFORMANT ADDRESS Mrs. Graceana McCoolle, Ridgeley, WV - wife			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b) _____									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>12/8</i> 19 <i>86</i> to <i>12/8</i> 19 <i>86</i> that (I) (we) last saw the deceased alive on <i>12/8</i> 19 <i>86</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE <i>W. Guy Fiscus</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/09/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. GUY FISCUS				MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-10-1986		23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502				25. DATE REC'D. BY REGISTRAR DEC 11 1986		25b. REGISTRAR'S SIGNATURE <i>John T. ...</i>			

The following is a list of the names of the persons who have been
 named in the report of the Committee on the Administration of the
 Government of the District of Columbia, as of the 1st day of
 January, 1900. The names are given in alphabetical order, and
 are followed by the names of the persons who have been named in
 the report of the Committee on the Administration of the Government
 of the District of Columbia, as of the 1st day of January, 1900.
 The names are given in alphabetical order, and are followed by the
 names of the persons who have been named in the report of the
 Committee on the Administration of the Government of the District
 of Columbia, as of the 1st day of January, 1900.

027222 DEC 16 1986

STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 3 4 0 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARY HELENE MCGANN			2a. DATE OF DEATH MONTH DAY YEAR 12 8 86			2b. HOUR M				
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR July 19, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.				
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) hwf		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.			13b. COUNTY Allegany		13c. CITY OR TOWN Frostburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 33 Teaberry Lane 21532	
14. FATHER'S NAME FIRST MIDDLE LAST Dominic Martin			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Helmstetter							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT ADDRESS Margaret Tam same as 13a-e.						

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: <u>Rheumatoid arthritis</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and I am the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Gregory M.D.</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>8 Dec 86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/11/86		23c. NAME OF CEMETERY OR CREMATORY Restlawn Memorial Park LaVale Allegany MD		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Leasure-Stein Funeral Home, Inc. 230 Baltimore Ave. Cumberland, MD 21502				25a. DATE REC'D. BY REGISTRAR DEC 15 1986		25b. REGISTRAR'S SIGNATURE <u>Julia T. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. The permit requires completion of pages 1 and 2, which would be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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27360 DEC 17 1986

9 6 3 3 4 0 4

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME
(TYPE OR PRINT) **James A. Mc Kenzie**

2a. DATE KNOWN OF DEATH ☒ MONTH ☐ DAY ☐ YEAR **12 10 1986** 2b. HOUR **015A**

3. SEX **Male** 4. RACE **White** 5. DATE OF BIRTH **Mar. 22, 1913** 6. AGE (IN YEARS) **73** YRS. 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) **Maryland** 7b. CITIZEN OF WHAT COUNTRY? **U.S.A.** 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH **Allegany** MD.

2c. DATE PRONOUNCED DEAD **12 10 1986** 2d. HOUR **1015**

10. CITY OR TOWN OF DEATH **Frostburg** 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) **Frostburg Community Hospital** 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) **Carpenter** 12b. KIND OF BUSINESS OR INDUSTRY **Tire Co.**

13a. STATE **Maryland** 13b. COUNTY **Garrett** 13c. CITY OR TOWN **Grantsville** 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ 13e. STREET ADDRESS **Rt. 2, Box 12 A, 21536**

14. FATHER'S NAME FIRST MIDDLE LAST **Frank Mc Kenzie** 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST **Gretta King**

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) **No** (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. **214-07-0299** 17. INFORMANT ADDRESS **Pauline Mc Kenzie, Same as 13e**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Ventricular Fibrillation**
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) **Arteriosclerotic Heart Disease**
DUE TO, OR AS A CONSEQUENCE OF
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH **1 hr**

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).
Diabetes; hypertension; chronic alcohol abuse

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion

ACTUAL SIGNATURE **Paul Snow** M.D. **Dptx** MEDICAL EXAMINER DATE SIGNED **12/10/86**

EXAMINER'S NAME (TYPE OR PRINT) **Paul Snow, M.D.** ADDRESS **Memorial Hosp, Cumberland, Md.**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) **Burial** 23b. DATE **Dec. 13 '86** 23c. NAME OF CEMETERY OR CREMATORY **St. Patricks Cem.** 23d. LOCATION CITY OR TOWN COUNTY STATE **Mt. Savage, Allegany, Md.**

24. FUNERAL DIRECTOR NAME ADDRESS **Durst Funeral Home, Frostburg, Md.** 25a. DATE RECD. BY REGISTRAR **DEC 16 1986** 25b. REGISTRAR'S SIGNATURE

BP
DHMH - 17
(VR A15 ME (1))
15M 2/80

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL OFFICE ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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027219 DEC 16 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 3 4 0 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARY D. MILLER			2a. DATE OF DEATH MONTH DEC. DAY 4 YEAR 1986		2b. HOUR 11:am
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH JULY 31 1906		6. AGE (IN YEARS LAST BIRTHDAY) 80	IF UNDER 1 YEAR MONTHS _____ DAYS _____
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.	
10. CITY OR TOWN OF DEATH BARTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 1 BOX 51		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSE WIFE		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD			13b. COUNTY ALLEGANY	13c. CITY OR TOWN BARTON	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST JAMES MIDDLE _____ LAST O'NEILL			15. MOTHER'S MAIDEN NAME FIRST MARY MIDDLE _____ LAST O'MALLERY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 215 10 8084		17. INFORMANT MARY C. MILLER ADDRESS BARTON, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) End stage liver disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Sunil Gupta</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SUNIL GUPTA		22e. ADDRESS 69 GREEN ST., CUMBERLAND, MD. 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/7/86		23c. NAME OF CEMETERY OR CREMATORY PHILOS CEMETERY	
23d. LOCATION WESTERNPORT ALLEGANY MD.					
24. FUNERAL DIRECTOR NAME <i>Boal</i> BOAL FUNERAL SERVICE, P.A. WESTERNPORT, MD. 21562		25a. DATE REC'D. BY REGISTRAR DEC 15 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit should be filed with the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

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DEC. 1 11:00 AM

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

3 3 4 0 6

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARK CALVIN MOWER			2a. DATE OF DEATH MONTH DAY YEAR December 13, 1986		2b. HOUR 9:30 M				
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 06-24-1903		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ret. finisher		12b. KIND OF BUSINESS OR INDUSTRY glass co.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Mark Mower			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Hensel						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-05-4529		17. INFORMANT ADDRESS Mrs. Leona I. Mower, Cumberland, MD - wife				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cordisrhythmic arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Aspirin - granule</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>48h</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) this hospital attended the deceased from <u>12-11</u> , 19 <u>85</u> , to <u>12-13</u> , 19 <u>85</u> , that (2) (we) last saw the deceased alive on <u>12-13</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Bollino</u>			DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>12-15-86</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Bollino			22e. ADDRESS 955 Frederick St. Cumberland, Md. 21502						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-17-1986		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD		
24. FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, MD 21502									

BP

DEC 22 1986
JULIA BENTON REGISTER

ALTON 1846

ALTON 1846

ALTON 1846



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.	
1. FOR STATE REGISTRAR			2a. DATE OF DEATH			2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)			2b. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
OTHA ALBERT MYERS			December 14, 1986			12:45 P.M.	
3. SEX			4. RACE			5. DATE OF BIRTH	
Male			White			Dec. 26, 1909	
6. AGE (IN YEARS LAST BIRTHDAY)			7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			8. IF UNDER 1 YEAR	
76 YRS.			Maryland			MONTHS DAYS	
9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION	
Allegany MD.			Cumberland			Memorial Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			13. STREET ADDRESS / ZIP CODE	
Bus Driver						Rt. 2 Box 31 21555	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES?	
Walson O. Myers			Elsa B. Starlipper			(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	
17. INFORMANT			18. CAUSE OF DEATH			19. SOCIAL SECURITY NO.	
Laura E. Myers same as 13a-e.			Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Advanced Ca. Lung DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			20. DATE OF OPERATION	
21a. ACCIDENT WAS UNDERLYING			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED	
(IF EITHER, NOTIFY MEDICAL EXAMINER)			HOUR A.M. MONTH DAY YEAR			(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION	
WHILE NOT WHILE AT WORK			(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE			22c. DATE SIGNED	
22b. SIGNATURE			DEGREE			22c. DATE SIGNED	
22b. SIGNATURE			MD			12/16/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			22f. DATE REC'D. BY REGISTRAR	
Dr. Qamar Zaman			Memorial Hospital Medical Bldg. Cumberland, MD 21502			DEC 22 1986	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY	
Burial			12/17/86			Oldtown Methodist	
24. FUNERAL DIRECTOR			25. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE	
NAME			25. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE	
Leasure-Stein Funeral Home			DEC 22 1986			Julia Tinson-Baker	
230 Baltimore Ave. Cumberland, MD 21502							

05833 11 343



026504 DEC - 3 1986

EICHORN FUNERAL HOME
STATE REGISTRAR LONA CONING MD 21539DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WILLIAM M. NICHOL			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 2, 1986			2b. HOUR 8:35 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 18, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 66	
7a. BIRTHPLACE (STATE OR FOREIGN) Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Ind.	
12b. KIND OF BUSINESS OR INDUSTRY 1							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md Allegany Frostburg							
13b. COUNTY Allegany		13c. CITY OR TOWN Frostburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rt 1, Box 326 21532	
14. FATHER'S NAME William MIDDLE Nicol				15. MOTHER'S MAIDEN NAME Edna MIDDLE Leora MCKENZIE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT ADDRESS Mrs. Jean Nichol Rt 1, Box 326 Frostburg, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrhythmia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASVD</i> DUE TO, OR AS A CONSEQUENCE OF (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Carcinoma of lung & multiple metastases</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>15m</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>L. Mazzucco</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-3-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BMG				22e. ADDRESS 912 SETON DRIVE, CUMBERLAND, MD 215			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 5, 1986		23c. NAME OF CEMETERY OR CREMATORY Restlawn Mem. Park La Vale Allegany		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR Eichorn-McKenzie Funeral Home Lonaconing, Md. 21539				25a. DATE REC'D. BY REGISTRAR DEC 8 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Dendron</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked either 18, 19, 20, or 21, the medical examiner must be notified.

02-0001 DEC-52

UNCLASSIFIED
DATE 10-10-2000 BY SP-6

DECEMBER 2, 1952

WILLIAM M. WILSON

ALLEGANY COUNTY

CARROLL HEART POSITION

WILLIAM M. WILSON
217-10-4112
LOCAL 10, BOX 320
STONINGTON, W. VA.



ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10-10-2000 BY SP-6

UNCLASSIFIED

027700 DEC 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please forward the completed pages 1 and 2 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. If item 21 is marked or item 18 shows any injury, or other trauma, except the medical examiner, please be notified and report at: if item 21 is marked or item 18 shows any injury, or other trauma, except the medical examiner, please be notified and report at:

FOR STATE REGISTRAR		STATE OF MARYLAND		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 6 3 3 4 0 2	
1- REGISTRAR		GEORGE-UPCHURCH		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)		2. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		3. CITIZEN OF WHAT COUNTRY?		4. BALTIMORE CITY OR COUNTY OF DEATH	
Eleanor E. Perry		West Virginia		U.S.A.		Allegany MD	
5. SEX		6. RACE		7. DATE OF BIRTH		8. AGE (IN YEARS LAST BIRTHDAY)	
Female		White		Jan. 28, 1903		83 YRS.	
9. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
West Va. Mineral		Cumberland		Sacred Heart Hospital		Homemaker	
13. STATE		14. CITY OR TOWN		15. INSIDE CITY LIMITS?		16. STREET ADDRESS / ZIP CODE	
West Va.		Ridgeley		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		196 Main Street / 26753	
17. FATHER'S NAME		18. MOTHER'S MAIDEN NAME		19. INFORMANT		20. ADDRESS	
John C. Byer		Cora		James M. Perry		Address same as #13 above.	
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		22. SOCIAL SECURITY NO.		23. DATE OF DEATH		24. HOUR	
No		214-07-0887		NOVEMBER 30 1986		5:48P M	
25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		26. IMMEDIATE CAUSE (a)		27. DUE TO, OR AS A CONSEQUENCE OF		28. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Massecle Pulmonary embolus						7 months	
29. PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		30. DATE OF OPERATION		31. CONDITION FOR WHICH OPERATION WAS PERFORMED		32. AUTOPSY?	
Surgery for Reversible sigmoid volvulus		11/24/86		Sigmoid volvulus		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
33. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		34. TIME OF INJURY		35. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)		36. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
		HOUR A.M. MONTH DAY YEAR				YES <input type="checkbox"/> NO <input type="checkbox"/>	
37. INJURY OCCURRED		38. PLACE OF INJURY		39. LOCATION		40. CITY OR TOWN	
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		COUNTY STATE	
41. I certify that (I) (this hospital) attended the deceased from		42. DATE OF OPERATION		43. DATE OF DEATH		44. DATE OF DEATH	
11/30/86		11/30/86		11/30/86		11/30/86	
45. SIGNATURE		46. DEGREE		47. ATTENDING PHYSICIAN		48. MEDICAL STAFF	
Andrew Stasko		MD		PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		DATE SIGNED	
49. PHYSICIAN'S NAME (TYPE OR PRINT)		50. ADDRESS		51. DATE REC'D. BY REGISTRAR		52. REGISTRAR'S SIGNATURE	
DR. ANDREW STASKO		924 SETON DRIVE; CUMBERLAND, MD 21502		DEC 17 1986		Julia Davidson-Randall	
53. BURIAL, CREMATION, REMOVAL (SPECIFY)		54. DATE		55. NAME OF CEMETERY OR CREMATORY		56. LOCATION	
Burial		12-3-86		Sunset Memorial Park		Cumberland-Allegany-MD	
57. FUNERAL DIRECTOR		58. DATE REC'D. BY REGISTRAR		59. REGISTRAR'S SIGNATURE		60. DATE REC'D. BY REGISTRAR	
George-Upchurch Funeral Home, P.A.		DEC 17 1986		Julia Davidson-Randall		DEC 17 1986	
202 Greene Street-Cumberland, Maryland 21502							

Alfonso A. Pelly

27119 DEC 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 8 shows any injury, or other traumatic event, the medical examiner must be notified of page 4.

FOR
STATE
REGISTRAR

SCARPELLI FUNERAL HOME
108 VIRGINIA AVE
CUMBERLAND, MD 21502

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FREDERICK WILLARD PORTER			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 5, 1986		2b. HOUR 8:50P_M
3 SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 11-28-1903		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DE	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		12b. KIND OF BUSINESS OR INDUSTRY Post Office
13a. STATE MD			13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Frank J. Porter			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alberta Eberhardt		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-10-2677		17. INFORMANT ADDRESS Mrs. Evelyn G. Porter, Cumberland, MD-wife	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (and not) view the body after death.					
22b. SIGNATURE Baljeet Mahal		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BALJEET MAHAL, M.D.		22e. ADDRESS 909-B SETON DRIVE CUMBERLAND, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12-08-1986	23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502		25a. DATE REC'D. BY REGISTRAR DEC 10 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

021100100

FOR WITNESS AND
SIGNED AND DATED

DECEMBER 2, 1962

WILLARD

ALLEGANY COUNTY

SACRED HEART HOSPITAL

JOHN J. JOHNSON

BY: J. J. JOHNSON, M.D.

BY: J. J. JOHNSON, M.D.

029254 JAN - 5 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DURST FUNERAL HOME
57 FROST AVE.
FROSTBURG, MD 21532STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 3 4 1 1

REG. NO.

1. DECEASED NAME FIRST MIDDLE LAST MELISSA WILSON PRICE			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER, 28, 1986		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 18, 1895	6. AGE (IN YEARS LAST BIRTHDAY) 91		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.		
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper	12b. KIND OF BUSINESS OR INDUSTRY Beer Co.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Allegany	13c. CITY OR TOWN Frostburg	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Henry B. Wilson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virgie Pearce		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220 38 0231	17. INFORMANT ADDRESS 29 W. College Enoch W. Price, Frostburg, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Enter pneumonia</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>George B. Mazocco</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/29/86	
22d. PHYSICIAN'S NAME (TYPE PRINT) VICTOR E. MAZZOCCO, M.D.		22e. ADDRESS 912 SETON DRIVE CUMBERLAND, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Dec. 31 '86	23c. NAME OF CEMETERY OR CREMATORY Frostburg Mem. Park	23d. LOCATION CITY OR TOWN COUNTY Frostburg, Allegany, Md.		
24. FUNERAL DIRECTOR NAME Durst Funeral Home, Frostburg, Md.		25a. DATE REC'D. BY REGISTRAR DEC 31 1986	25b. REGISTRAR'S SIGNATURE <u>Julia T. ...</u>		

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

COLLON LIPED

029604 JAN 11 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXAMINED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH		MONTH	DAY	YEAR	HOUR
		THELMA			VIRGINIA	RAINES	X		12	29	86	0750
3. SEX	4. RACE	5. DATE OF BIRTH		MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.		IF UNDER 24 HRS.		2d. DATE PRONOUNCED DEAD
Female	Cau	9/1/04					82 YRS.	MONTHS	DAYS	HOURS	MIN.	12 29 86 0750
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7c. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
W. Va.		U.S.A.				Allegany MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Cumberland		Memorial Hospital				Housewife						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		99999		
W. Va.		HARDY		Moorefield		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		130 W Brighton				
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME								
FIRST MIDDLE LAST				FIRST MIDDLE LAST								
EDWARD LILLER				VIRGINIA ROTRUCK								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
No				234-40-2837		JUANITA See		FISHER, W. Va.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Pulmonary embolism												
DUE TO, OR AS A CONSEQUENCE OF												
888 } (b) Post-operative hip fracture repair												
DUE TO, OR AS A CONSEQUENCE OF												
(c) Fractured hip												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
Arteriosclerotic heart disease: obesity												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
12/28/86				Fractured hip				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> P.M. 12 27 1986				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
								Patient fell at home				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION				
				At home				130 W. Brighton Moorefield W. Va.				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .												
TITLE (SPECIFY)												
M.D. Dpty MEDICAL EXAMINER												
ACTUAL SIGNATURE				DATE SIGNED				12/29/86				
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS								
Paul Snow, M.D.				Memorial Hospital, Cumberland Md 21502								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		STATE		
Burial				1/2/87		Olivet Cemetery		MOOREFIELD, W. Va.		HARDY		
24. FUNERAL DIRECTOR NAME				ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
J. Thomas Fraley				Moorefield, W. Va.		JAN 12 1986		Julia Henderson-Kendall				

07/B4
R5M-

BP

FORM 17
(R 11-76 ME (5))

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their filing remove completion papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY Ruth Rice			2a. DATE OF DEATH MONTH DAY YEAR 12 27 86			2b. HOUR 7⁵⁸ P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 29, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	
7a. BIRTHPLACE (COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Village Nursing H.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret Employee	
12b. KIND OF BUSINESS OR INDUSTRY Fiber Co.							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Allegany 13c. CITY OR TOWN Cumberland 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
14. FATHER'S NAME FIRST MIDDLE LAST Harry G. Rice				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary J. Bowden			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-10-4204		17. INFORMANT ADDRESS Robert E. Rice Cumberland, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Serious disorder							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE George B. MD				DEGREE MD		22c. DATE SIGNED 12/29/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 30, 1986		23c. NAME OF CEMETERY OR CREMATORY Pleasant Grove C.		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD	
24. FUNERAL DIRECTOR NAME William G. Kight				ADDRESS Cumberland, MD		25a. DATE REC'D. BY REGISTRAR JAN 2 1987	
				25b. REGISTRAR'S SIGNATURE Julia T. Ponder			

022013-1-21

Female	White	Nov. 29, 1904	82
MD	USA		Allegany
Frostburg	Frostburg Village Nursing H. Res. Employee	Yipco Co.	21802
MD	Allegany	Cumberland	Green City Towers Apart
Harry	G. Rice	Mary	J. J.
No	217-16-4204 Robert E. Rice	Cumberland, MD	

William G. Knight
Cumberland, MD
Dec. 30, 1986 Pleasant Grove C. Cumberland Allegany MD

027359 DEC 1986

FOR
FAC
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST JAMES			MIDDLE LEWIS			LAST RIEHL			2b. DATE KNOWN OF DEATH DEC 12 1986			2d. HOUR 11:24		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 13 1919		6. AGE (IN YEARS) (LAST BIRTHDAY) 67 YRS		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD DEC 12 1986		2d. HOUR 11:24					
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD					
10. CITY OR TOWN OF DEATH CUMBERLAND				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COLUMBIA GAS CO OF MARYLAND				12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE MARYLAND				13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 623 LINCOLN STREET				21502			
14. FATHER'S NAME FIRST MIDDLE LAST WALTER HENRY RIEHL						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EDNA JOHNSTON											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. WW11		17. INFORMANT JANE RIEHL				ADDRESS 21502							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Disease -</u> DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE Francisco Reyes				TITLE (SPECIFY) Deputy				DATE SIGNED Dec-12-86									
EXAMINER'S NAME (TYPE OR PRINT) DR. FRANCISCO REYES				ADDRESS SACRED HEART HOSP. CUMBERLAND MD.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE DEC 15 1986		23c. NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL PARK				23d. LOCATION CITY OR TOWN COUNTY STATE CUMBERLAND ALLEGANY MARYLAND							
24. FUNERAL DIRECTOR NAME SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MARYLAND				ADDRESS				25a. DATE REC'D. BY REGISTRAR DEC 16 1986									

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM BM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

03131 153

RECEIVED
JAN 17 1964
FBI - NEW YORK

RECEIVED
JAN 17 1964
FBI - NEW YORK

027532 DEC 18

SHAFFERS FUNERAL HOME

230 E. MAIN STREET
ROMNEY, WV 26757DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0

3 3 4 1 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARTHA MAE RINKER			2a. DATE OF DEATH MONTH DAY YEAR 12 07 86		2b. HOUR 3:00 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 22 1918		
6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE WV			13b. COUNTY Hampshire		13c. CITY OR TOWN Romney	
14. FATHER'S NAME FIRST MIDDLE LAST Isaac Reed			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lena VanMeter			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 236-42-0165		17. INFORMANT ADDRESS Kathy Hawse, Rt. 2, Box 43, Kirby, WV		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ENDSTAGE Metastatic Melanoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>G. Wagner</u> M.D.				22c. DATE SIGNED 12-8-86		
22d. PHYSICIAN'S NAME (TYPE COMPLETE) WAGONER, GARY M.D.				22e. ADDRESS 925 BISHOP WALSH ROAD CUMBERLAND, MD. 21502		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/10/86		23c. NAME OF CEMETERY OR CREMATORY Indian Mound Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Romney Hampshire WV						
24. FUNERAL DIRECTOR NAME Keith S. Shaffer				25. DATE REC'D. BY REGISTRAR DEC 11 1986		
26. REGISTRAR'S SIGNATURE Shaffer Funeral Home, Inc., Romney, WV				27. REGISTRAR'S SIGNATURE <u>Alia Tidmore-Pendleton</u>		

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate must be obtained.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copies of pages 1 and 2 and place them in the container for removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

029618 JAN 15

FOR
STATE
REGISTRAR

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST ROBERT			MIDDLE LEE			LAST ROACH			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 12-26 19 86			2b. HOUR M P				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10-22-1924		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 62		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12-27 19 86			2d. HOUR M P				
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.							
10. CITY OR TOWN OF DEATH Cumberland				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 107 East First Street								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired				12b. KIND OF BUSINESS OR INDUSTRY Electric Co.			
13a. STATE Maryland				13b. COUNTY Allegany				13c. CITY OR TOWN Cumberland				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 107 East First St., 21502			
14. FATHER'S NAME FIRST MIDDLE LAST Enoch Roach								15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eula Peer											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 218-16-3782				17. INFORMANT ADDRESS Mrs. Mildred Roach, Cumberland, Md. Wife											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 888 IMMEDIATE CAUSE (a) Right sub-dural hematoma (Contra-Coup) DUE TO, OR AS A CONSEQUENCE OF Closed Head Injury, left (b) DUE TO, OR AS A CONSEQUENCE OF Acute & Chronic Alcohol Abuse (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours 24 hours			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION 12-2-1986				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Laceration Right Eye Brow										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 12-26 19 86				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Patient Fell While Intoxicated											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) At Home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 107 East First St., Cumberland, Md. 21502											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <i>Dr. Paul Snow</i>				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER				DATE SIGNED 12-29-1986							
EXAMINER'S NAME (TYPE OR PRINT) Dr. Paul Snow MD				ADDRESS Memorial Hospital, Cumberland, Md.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-30-1986				23c. NAME OF CEMETERY OR CREMATORY Rocky Gap VA Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.							
24. FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, Md. 21502												25a. DATE REC'D. BY REGISTRAR JAN 12 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Dutton Radford</i>					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

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027101 DEC 16

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please detach carbon papers. Pages 1 and 2 should be filed with 77 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 1B shows injury, or other traumatic event, the medical examiner must be notified at once.

FOR SCARPELLI FUNERAL HOME
STATE REGISTRAR 108 VA. AVE. CUMB. MD.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CARL EDWARD ROBINETTE			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 6, 1986		2b. HOUR 5:50 M
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 03-03-1912	6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.		
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired Foreman	12b. KIND OF BUSINESS OR INDUSTRY Gas Co.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST (nfn)			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pansy Schell Hughes		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214072705	17. INFORMANT ADDRESS Mrs. Estella Robinette, Cumberland, MD-wife		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Esophagus</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>12/6/86</u> to <u>12/6/86</u> , that (I) (we) last saw the deceased alive on <u>12/6/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Aswaph</u>		DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SIVAN A. PILLAI, M.D.		22e. ADDRESS 915 SETON DRIVE CUMBERLAND, MD. 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12-09-1986	23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD		25a. DATE REC'D. BY REGISTRAR DEC 10 1986			

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CARL EDWARD FROST

ALLEGEDLY

SACRED HEART HOSPITAL

216022002

2000 COTTON FIBER

CLAYTON A. DAVIS, JR. 10015 10015 10015

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please review page 4. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 3 4 1 8

FOR
STATE
REGISTERAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RICHARD R. ROLEK			2a. DATE OF DEATH MONTH DAY YEAR December 13, 1986			2b. HOUR P M 10:10 M	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 04-04-1936		6. AGE (IN YEARS LAST BIRTHDAY) 50 YES	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) machinist	
13a. STATE WV		13b. COUNTY Mineral		13c. CITY OR TOWN Keyser		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Casimer Rolek				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Koscielska			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 191-26-8523		17. INFORMANT ADDRESS Delores Micholak, Philadelphia, PA - sister			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe failure DUE TO, OR AS A CONSEQUENCE OF (b) Cholangitis DUE TO, OR AS A CONSEQUENCE OF (c) Chronic pancreatitis							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Wound dehiscence, Common Duct stenosis							
19a. DATE OF OPERATION 19 Sept, 10 Oct, 28 Nov		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cholangitis / Abscess / Stricture		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACT OR INJURY WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> WHITE <input type="checkbox"/> HOT WHITE <input type="checkbox"/> AT WORK		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED <input type="checkbox"/> WHITE <input type="checkbox"/> HOT WHITE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from 17 Sept 1986 to 13 Dec 1986 that (I/we) last saw the deceased alive on 13 Dec 1986 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not see the body after death, so state.)							
22b. SIGNATURE Dr. W. Miltenberger, M.D.				DEGREE M.D.		22c. DATE SIGNED 13 Dec 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Miltenberger				22e. ADDRESS 122 S. Centre St. Cumberland, Md. 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-19-1986		23c. NAME OF CEMETERY OR CREMATORY St. Dominic Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Philadelphia PA	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md 21502				25. REGISTRAR'S SIGNATURE Julia Anderson-Rudolph			

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SEP 18 1960

28536 DEC 31

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked as item 18, then item 18 must be signed and dated.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
3. DECEASED NAME (TYPE OR PRINT)		4. RACE		5. DATE OF BIRTH	
WILLIAM M. ROWLEY		WHITE		JULY 2 1910	
6. SEX		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
MALE		MARYLAND		USA	
9. BALTIMORE CITY OR COUNTY OF DEATH		10a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		10b. KIND OF BUSINESS OR INDUSTRY	
Allegany MD.		RETIRED		HAZELWOOD CONST. CO.	
11. CITY OR TOWN OF DEATH		12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13. STREET ADDRESS / ZIP CODE	
Cumberland		Memorial Hospital & Medical Center		RFD# 3 BOX# 496 15522	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.	
JAMES RANDALL ROWLEY		ISA VIRGINIA HAINES		217-10-6808	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Aspiration Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Lymphocytic Leukemia</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>		19. DATE OF OPERATION	
MARY ROWLEY RFD# 3 BOX# 496 BEDFORD PA				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. PHYSICIAN'S NAME (TYPE OR PRINT)		22b. ADDRESS		22c. DATE SIGNED	
Dr. Q. Zaman		Memorial Hospital & Medical Center Cumberland, MD 21502		12/24/86	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		DEC 27 1986		SUNSET MEMORIAL PARK	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MARYLAND		DEC 29 1986		Julia Denton Radabaugh	



026506 DEC-3-86

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECLARANT NAME (TYPE OR PRINT) Minnie Virginia Russell			2a. DATE OF DEATH MONTH DAY YEAR December 3 1986			2b. HOUR M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 8 1897		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD.			
10. CITY OR TOWN OF DEATH Midland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Box 92 Midland 21542				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b. KIND OF BUSINESS OR INDUSTRY House	
13a. STATE Maryland			13b. COUNTY Allegany		13c. CITY OR TOWN Midland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST J. Olin Wilhelm			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada Garlitz						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 217 14 4671		17. INFORMANT ADDRESS Mrs. Mary Devlin Box 92 Midland Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>								PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>11-23</u> , 19 <u>86</u> , to <u>11-29</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>11-29</u> , 19 <u>86</u> , and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.									
22b. SIGNATURE Mary Ann D. Moore MD			DEGREE			22c. DATE SIGNED 12-3-86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARY ANN D. MOORE MD			22e. ADDRESS 404 BYRN ST, CAMBRIDGE, MD 21613						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/6/86		23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Barton Allegany Maryland		
24. FUNERAL DIRECTOR NAME <u>Walter Boals Jr.</u> Boals Funeral Service Westernport Md. 21562						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 8 1986 Julia Davidson-Landau			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the dissection costs be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 above any injury, or other traumatic event, the medical examiner must be notified.

BP _____

DHMH - 16 60M 7/84

(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

December 3, 1968

Memorandum

TO: Mr. Tolson

FROM: Mr. [illegible]

RE: [illegible]

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

RUTH

H

SCOTT

2a. DATE OF DEATH MONTH DAY YEAR

DECEMBER 29, 1986

2b. HOUR

2:25A

M

3. SEX

female

4. RACE

white

5. DATE OF BIRTH

MONTH DAY YEAR
04-26-1899

6. AGE (IN YEARS LAST BIRTHDAY)

87

YRS.

IF UNDER 1 YEAR

MONTHS

DAYS

IF UNDER 24 HRS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Ohio

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Allegany

MD

10. CITY OR TOWN OF DEATH

CUMBERLAND

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

MEMORIAL HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

housewife

12b. KIND OF BUSINESS OR INDUSTRY

own home

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD

13b. COUNTY

Allegany

13c. CITY OR TOWN

Oldtown

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE

none/21555

14. FATHER'S NAME

FIRST MIDDLE LAST
Phillip H. Hilderbrand

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST
Mary Taylor

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES

no

16b. SOCIAL SECURITY NO.

229-03-5754

17. INFORMANT

ADDRESS

Mrs. Wilda McLaughlin, Oldtown, MD - daughter

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐ AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (the hospital) attended the deceased from 12/29/86 to 12/29/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, did not attend the body after death.)

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

DR. FISCUS

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐MEMORIAL HOSPITAL MEDICAL BUILDING
CUMBERLAND, MARYLAND 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

12-31-1986

23c. NAME OF CEMETERY OR CREMATORY

Davis Memorial Cem.

23d. LOCATION

CITY OR TOWN

CUMBERLAND

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME ADDRESS
James F. Scarpelli, Cumberland, MD 21502

25a. DATE REC'D. BY REGISTRAR

DEC 31 1986

25b. REGISTRAR'S SIGNATURE

Julia Davidson-Randall

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to take.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please return this certificate to the State Department of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

BP

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NON COLLECT LITERA

at 20/10 - 22 - 24 - 25
4/20/10

1883-1884

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
Franch					Sgaggero	12/12/86				10:40 PM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Male		White		8 1 95		91					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
United States		United States				Allegany County MD					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Frostburg			Frostburg Community Hospital								
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		
Maryland			Allegany		Frostburg		YES		1 Kaylor Circle 21532		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
YEMO			SGAGGERO			KATORINA ???					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT						
NO			N.A.		FROSTBURG, MD 21532 MR. YEMO SGAGGERO, 65 WRIGHT ST.						

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u>					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARDIAC ARRHYTHMIA</u>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>RECURRENT LEFT PLEURAL EFFUSION PNEUMONIA</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 20</u> , 19 <u>86</u> , to <u>Dec 11</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Dec. 11</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>S Chang M.D.</u>		22c. DATE SIGNED <u>12/14/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Dr. S. Chang M.D.		Hecks Plaza Frostburg Md 21532			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		12/15/86		ST. MICHAEL'S CEM	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
FROSTBURG ALLEGANY MD		DEC 16 1986		<u>Julia Fisher-Rudner</u>	

24. FUNERAL DIRECTOR <u>J. Sowers</u>		60 W. MAIN ST. FROSTBURG		25. DATE REC'D. BY REGISTRAR	
SOWERS FUNERAL HOME				DEC 16 1986	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

BP

Handwritten notes and markings, including a large 'X' and various illegible text fragments.

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RECEIVED

029449 JAN - 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOHN FRANCIS SHAFFER			2a. DATE OF DEATH MONTH DAY YEAR December 31, 1986		2b. HOUR A 2:06 M					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 9 1928		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.				
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Operator		12b. KIND OF BUSINESS OR INDUSTRY Construct		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Locust Grove		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13. STREET ADDRESS / ZIP CODE Rt. 1, Box 285 / 21502		
14. FATHER'S NAME Paul H. Shaffer				15. MOTHER'S MAIDEN NAME Angela Jenkins						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 216-22-7126		17. INFORMANT Mary Jane Shaffer- same as above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Severe Hematemesis DUE TO, OR AS A CONSEQUENCE OF (c) Advanced Ca. Colon APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Dr. Zaman			DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/31/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Zaman			22e. ADDRESS Memorial Hospital Medical Building Cumberland, Md. 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1-2-87		23c. NAME OF CEMETERY OR CREMATORY Rest Lawn Mem Gard		23d. LOCATION CITY OR TOWN COUNTY STATE KaVale Allegany Md.			
24. FUNERAL DIRECTOR NAME John J. Hafer, Jr					ADDRESS LaVale, Md		25a. DATE REC'D BY REGISTRAR JAN 5 1987		25b. REGISTRAR'S SIGNATURE John J. Hafer, Jr	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please re-submit this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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29562 JAN 12 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) KATE NEVADA SHAFFER			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 28, 1986		2b. HOUR 1:30 P M
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 05/30/1893	6. AGE (IN YEARS LAST BIRTHDAY) 93		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD		
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE PA	13b. COUNTY Bedford	13c. CITY OR TOWN Hyndman	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Reese		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beuna Eicher			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-32-3365	17. INFORMANT ADDRESS Martha I. Cook, Bx 535, R D 1, Hyndman, PA			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Insufficiency</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH —
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASHD - CHF - COLO</u>		—
DUE TO, OR AS A CONSEQUENCE OF (c) —		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11-17</u> , 19 <u>86</u> , to <u>12-28</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12-27-86</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (they) did not view the body after death.			
22b. SIGNATURE <u>Dr. John T. Whitmore MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 12-29-86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. JOHN T. WHITMORE		22e. ADDRESS 1068 National Hwy LaVale, Maryland 21502	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/31/86	23c. NAME OF CEMETERY OR CREMATORY Hyndman Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Hyndman, Bedford County, PA
24. FUNERAL DIRECTOR <u>Harvey H. Zeigler</u>		25a. DATE REC'D. BY REGISTRAR JAN 05 1987	25b. REGISTRAR'S SIGNATURE <u>Julia Dindon-Randall</u>

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove the papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other notable event, the medical examiner must be notified at once.

BP

DHMS - 10:00M 7/84
(VRA 15, 4)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

SCARPELLI FUNERAL HOME
108 VIRGINIA AVE
CUMBERLAND, MD 21502

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EDGAR FINLEY SHATZER			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 04 1986			2b. HOUR M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Utility Co.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland			13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Conrad Shatzer			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sidney Rebecca Daniels			13e. STREET ADDRESS / ZIP CODE Route 4, Box 362 --21502			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-10-5237		17. INFORMANT ADDRESS Mr. Royce F. Shatzer, Cumberland, Md. Son				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung</u> DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 MONTH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>86</u> , to <u>12/4</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12/4</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE BMG					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 12/6/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS 912 SETON DRIVE CUMBERLAND, MD 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-7-1986		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.		
24. FUNERAL DIRECTOR NAME James F. Scarpelli, ADDRESS					25a. DATE REC'D. BY REGISTRAR DEC 10 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Rendall		

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 3 4 2 6

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (WRITE OR PRINT) MARY BLACKLIN SHEARS			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 17, 1986			2b. HOUR 2:00P M				
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 08-04-1900		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.				
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY own home		
13a. STATE WV			13b. COUNTY Mineral		13c. CITY OR TOWN Fort Ashby		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE none/26719 99999	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Blacklin					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eleanor Grimes					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 213-24-5546		17. INFORMANT ADDRESS Mr. Charles R. Hahn - Fort Ashby, WV - son					
18. CAUSE OF DEATH (Enter only one cause per line to be filled in) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Renal Failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>CHF + PAD</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>ASCVD</i>										
9a. DATE OF OPERATION			9b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (a) this hospital attended the deceased from <i>Dec. 16, 1986</i> to <i>Dec. 17, 1986</i> , that (b) (we) last saw the deceased on <i>Dec. 16, 1986</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (b) (we) did (and) (did not) see the body after death.										
22b. SIGNATURE <i>T. Williams</i>			DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>12-18-86</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. T. WILLIAMS			22e. HOSPITAL MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-19-1986		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD		
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502					25a. DATE REC'D. BY REGISTRAR DEC 22 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Sanborn-Rodgers</i>			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 3 4 2 1

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (Last, first, middle) HUMBERT L. SHORT			2a. DATE OF DEATH MONTH DAY YEAR December 12, 1986			2b. HOUR 9:05 AM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR apr. 17, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.				
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret Carman.		12b. KIND OF BUSINESS OR INDUSTRY Rail Road		
13a. STATE MD			13b. CITY OR TOWN Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Oldtown Rd Oldtown Manor Apt. 21502	
14. FATHER'S NAME FIRST MIDDLE LAST Albert L. Short				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nannie Marker						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 705-07-9667		17. INFORMANT ADDRESS Ada Pearl Short White Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Emphysema. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Intestinal obstruction. CHF.										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 2/5 , 19 84 , to 12/12 , 19 86 , that (I) (we) last saw the deceased alive on 12/12 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Dr. Halmos			DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/12/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Halmos					22e. ADDRESS Memorial Hospital & Medical Center Cumberland, MD 21502					
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE Dec. 14, 1986		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial P.		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD			
24. FUNERAL DIRECTOR NAME William G. Kight Cumberland, MD					25a. DATE REC'D. BY REGISTRAR DEC 17 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Radabaugh			

027-7 0-1938

Male	White	Apr. 17, 1938	88
USA	xx		
Allegany	Cumberland	xx	
Albert	Short	xx	
Ada Pearl Short White Ave.	xx		
Oldtown Manor Apt. 2100	xx		
Oldtown Rd.	xx		
Red Carman	xx		
Rail Road	xx		

William G. Night Cumberland, MD
Dec. 14, 1938 Sunset Memorial. Cumberland, Allegany MD

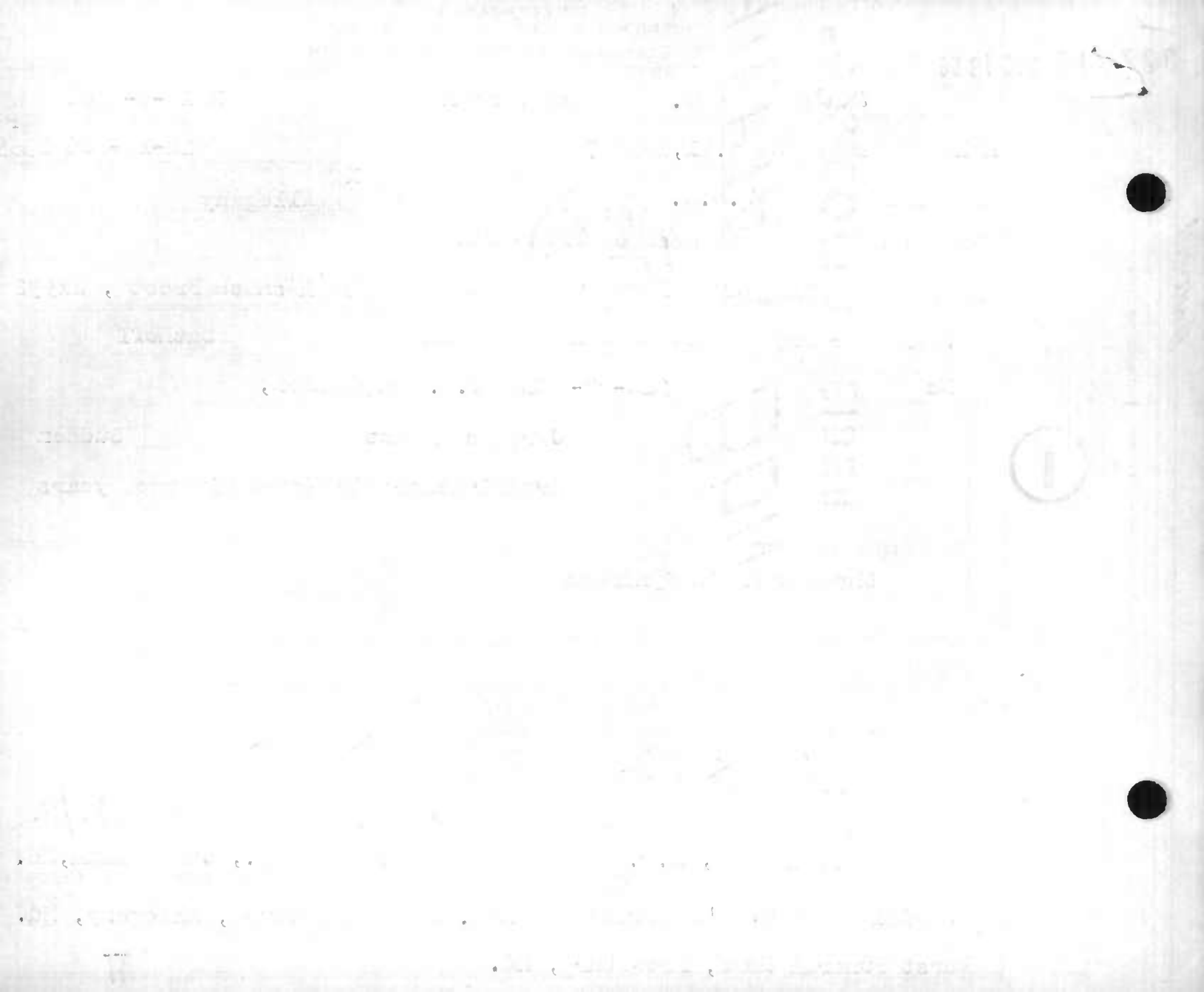
HAND-IN

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 6 3 3 4 2 8			
1. DECEASED NAME (TYPE OR PRINT) James W. Stephenson										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED 12-9-1986		2b. HOUR 1355	
3. SEX Male		4. RACE White		5. DATE OF BIRTH (MONTH DAY YEAR) Sept. 21, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD 12-10-1986		2d. HOUR 1355	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.			
10. CITY OR TOWN OF DEATH Frostburg				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 62 Meshach Frost Village				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Allegany 13c. CITY OR TOWN Frostburg										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 62 Meshach Frost, 21532	
14. FATHER'S NAME (FIRST MIDDLE LAST) John Henry Stephenson						15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Annie Sathoff							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 214-07-5312		17. INFORMANT ADDRESS J.E. Stephenson,							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Arteriosclerotic Heart Disease years DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Paul Snow						TITLE (SPECIFY) M.D.		MEDICAL EXAMINER		DATE SIGNED 12/10/86			
EXAMINER'S NAME (TYPE OR PRINT) Paul Snow, M.D.						ADDRESS Memorial Hosp., Cumberland, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Dec. 13 '86		23c. NAME OF CEMETERY OR CREMATORY Frostburg Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Frostburg, Allegany, Md.					
24. FUNERAL DIRECTOR NAME Durst Funeral Home, Frostburg, Md.						ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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FOR STATE REGISTRAR		Durst Funeral Home		STATE OF MARYLAND		8 6 3 3 4 2 9	
57 Frost Avenue		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		Frostburg, Md. 21532		CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Emily NMI Stewart				December 6, 1986		05:25AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.	
Female		White		Feb. 2, 1893		93 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		U.S.A.				Allegany County MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland		Sacred Heart Hospital		Teacher		School	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland		Allegany		Frostburg		13e. STREET ADDRESS / ZIP CODE	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
Thomas W. Williams		Mary Jane Rees		No		214059807	
17. INFORMANT ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
Mrs. Doris Haney, Frostburg, Md.		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Liver Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>obstructive jaundice</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cholangio-Carcinoma</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
Several weeks		old age. GI. bleeding due to esophageal ulcers. CHF		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)	
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 11/16/86 to 12/6/86, that (I) (we) last saw the deceased alive on 12/5/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.	
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
Dr. Sikander Sandhir		12/06/86		Dr. Sikander Sandhir		48 Tarn Terrace Frostburg, Md. 21532	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		Dec. 8, 1986		Eckhart Cemetery		Eckhart, Allegany, Md.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE	
Durst Funeral Home, Frostburg, Md.		DEC 11 1986		Julia Davidson-Randerson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	6	3	3	4	3	0		
1- FOR STATE REGISTRAR										REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST KARI F TASCHENBERGER										2a. DATE OF DEATH MONTH DAY YEAR 12 11 86							2b. HOUR 2152 P M	
3. SEX MALE			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR 09 06 13			6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS			IF UNDER 1 YEAR MONTHS DAYS 73		IF UNDER 24 HRS HOURS MIN. 73				
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.									
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic-Kelly-Springfield Tire			12b. KIND OF BUSINESS OR INDUSTRY									
13a. STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN CUMBERLAND			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 537 WINIFRED ROAD/21502						
14. FATHER'S NAME FIRST MIDDLE LAST Hugo Taschenberger			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Moore															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 214-05-9358			17. INFORMANT ADDRESS Ruth Ringler-Address same as # 13 above.												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
MEDICAL CERTIFICATION																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Donald Pepper			22c. DATE SIGNED 12/12/86			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>												
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 12-15-86			23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany-Maryland									
24. FUNERAL DIRECTOR George-Upchurch Funeral Home, PA..			25a. DATE REC'D. BY REGISTRAR DEC 17 1986			25b. REGISTRAR'S SIGNATURE Julia Tordson-Rudess												

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be procured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, this medical certificate must be notified police.

MEDICAL CERTIFICATION

SILCOX-MERRITT				STATE OF MARYLAND			
1- FOR STATE REGISTRAR				404 DECATUR STREET DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 6 3 3 4 3 1			
CUMBERLAND, MD 21502				CERTIFICATE OF DEATH			
2. DECEASED NAME FIRST MIDDLE LAST				2a. DATE OF DEATH MONTH DAY YEAR			
RENEE SUZANNE TEETER				12 23 86			
3. SEX				2b. HOUR			
FEMALE				10:55 M			
4. RACE				6. AGE (IN YEARS LAST BIRTHDAY)			
WHITE				16			
5. DATE OF BIRTH MONTH DAY YEAR				IF UNDER 1 YEAR			
03 02 70				MONTHS DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				IF UNDER 24 HRS			
MARYLAND				HOURS MIN.			
7b. CITIZEN OF WHAT COUNTRY?				9. BALTIMORE CITY OR COUNTY OF DEATH			
USA				ALLEGANY COUNTY MD.			
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
10. CITY OR TOWN OF DEATH				12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND				STUDENT- HIGH SCHOOL			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				13a. STREET ADDRESS / ZIP CODE			
SACRED HEART HOSPITAL				38 TRAILRIDGE ROAD BEL-AIR			
12. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. CITY OR TOWN			
13a. STATE				13c. CITY OR TOWN			
MARYLAND				CUMBERLAND			
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				15. MOTHER'S MAIDEN NAME			
FATHER'S NAME FIRST MIDDLE LAST				DEBORAH ANN SWAN			
RICHARD LEE TEETER				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
NO				16b. SOCIAL SECURITY NO.			
220-86-4254				17. INFORMANT ADDRESS			
DEBORAH KELLER 38 TRAILRIDGE ROAD CUMBERLAND				21502			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)							
PART 1. DEATH WAS CAUSED BY							
IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>							
DUE TO, OR AS A CONSEQUENCE OF							
(b) <i>Respiratory Failure</i>							
DUE TO, OR AS A CONSEQUENCE OF							
(c) <i>Hypoplastic Right Lung & Pneumonia</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.)				22b. SIGNATURE DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
DR. ROSARIO GONZAGA				925 BISHOP WALSH RD. CUMBERLAND, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (CHECK ONE)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL				DEC 27 1986		ROCKY GAP VETERANS CEMET. FLINTSTONE ALLEGANY MD.	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
SILCOX-MERRITT FUNERAL HOME, CUMBERLAND, MARYLAND				DEC 29 1986		Julia Davidson-Randall	

COLLECTION



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

3 3 4 3 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ALMA GERTRUDE UMSTOT			2a. DATE OF DEATH MONTH DAY YEAR December 24, 1986			2b. HOUR: 1:25 P. M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 27, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE West Va.		13b. COUNTY Mineral		13c. CITY OR TOWN Ft. Ashby		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Michael Staggs		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Bane		13e. STREET ADDRESS / ZIP CODE Dawn View Manor / 26719			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 234-96-0114		17. INFORMANT ADDRESS Carol Price - Short Gap, West Virginia			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension non Ketotic Diabetic Coma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 day</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>UTI & sepsis upon reinsertion</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (b) (this hospital) attended the deceased from <u>12/23</u> , 19 <u>86</u> , to <u>12/24</u> , 19 <u>86</u> , that (u) (we) lost saw the deceased alive on <u>12/24</u> , 19 <u>86</u> , and that (m) (our) opinion death occurred on the date and hour and from the causes stated above (u) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Anthony Bollino</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/24/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Anthony Bollino		22e. ADDRESS 955 Frederick Street Cumberland, MD 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/27/86		23c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Fort Ashby Mineral WV	
24. FUNERAL DIRECTOR NAME George-Upchurch Funeral Home, P.A. 202 Greene St., Cumb., MD 21502				25a. DATE REC'D. BY REGISTRAR DEC 30 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 3 4 3 3

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MAMIE LETTA UPOLE			2a. DATE OF DEATH MONTH DAY YEAR December 5, 1986		2b. HOUR 2:35 P.M.						
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 05-11-1904		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY own home			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 310 Cecilia Street/21502		
14. FATHER'S NAME FIRST MIDDLE LAST Sylvester George				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan (nmn)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-10-2393		17. INFORMANT ADDRESS Mr. Roger Patch, Sunrise, FL						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>OSD, A 5000</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>OSD, A 5000</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>no</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>1215 A St</u> <u>1215</u> <u>Allegany</u> <u>MD</u>						
22a. I certify that (I) (this hospital) attended the deceased from <u>12/5/86</u> to <u>12/5/86</u> , and that in (my/our) opinion death occurred on the date and hour and from the causes noted above, (I/we) (and (we/they) view the body after death.											
22b. SIGNATURE <u>Dr. Guy Fiscus</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>10/6/86</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Guy Fiscus			22e. ADDRESS Memorial Hospital Med. Bldg. Cumberland, MD 21502								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-08-1986		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park			23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD			
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502						25a. DATE REC'D. BY REGISTRAR DEC 10 1986					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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28474 DEC 30 1986

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 3 4 3 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NETTIE LOUISE VALENTINE			2a. DATE OF DEATH MONTH DAY YEAR December 17, 1986		2b. HOUR 5:41P M	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 06-22-1909		
6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN.		
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		9b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.		
10. CITY OR TOWN OF DEATH CUMBERLAND,		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) former employee		
12b. KIND OF BUSINESS OR INDUSTRY textile		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD		13c. CITY OR TOWN Cumberland		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 342 Dorn Avenue/21502				
14. FATHER'S NAME FIRST MIDDLE LAST Clifford Elliott			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary C. Lynch			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-07-4442		17. INFORMANT ADDRESS Mr. Joseph W. Elliott, Cumberland, MD-brother		
18. CAUSE OF DEATH (Enter only one cause per line, but list all causes.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiovascular Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute MI - infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>CAD, Atherosclerosis</i> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> ON WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) St. Marys		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE Cumberland Allegany MD		22a. I certify that (this hospital) attended the deceased from <i>Dec. 15, 1986</i> to <i>Dec. 17, 1986</i> that (I) (we) last saw the deceased alive on <i>Dec. 16, 1986</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If two (did) (did not) view the body after death.		22b. SIGNATURE <i>T. Williams</i> DEGREE <i>M.D.</i>		
22c. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. T. Williams		22d. ADDRESS MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND, 21502		22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-20-1986		23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD		24. FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, MD 21502		25a. DATE REC'D. BY REGISTRAR DEC 22 1986		
25b. REGISTRAR'S SIGNATURE <i>John F. Williams</i>						

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial or cremation. Then please remove carbon papers. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be assigned within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.DHMH - 16 60M 7/84
(VRA 15, 4)

Light Funeral Home				STATE OF MARYLAND	
FOR STATE REGISTRAR		309 Decatur St Cumberland, MD 21502		DEPARTMENT OF HEALTH AND MENTAL HYGIENE	
CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (LAST OR FIRST) Christine T. Walbert				2a. DATE OF DEATH MONTH DAY YEAR December 20, 1986	
3 SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 14, 1915	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County, MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret Cook		12b. KIND OF BUSINESS OR INDUSTRY School			
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland	
14. FATHER'S NAME FIRST MIDDLE LAST Andrew Kochis		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Czechovich		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215164877		17. INFORMANT ADDRESS Charles S. Walbert Cumberland, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Disseminated Intravascular Coagulation DUE TO, OR AS A CONSEQUENCE OF (b) Extensive Histocytic Lymphoma DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Gary Wagoner MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-22-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gary Wagoner, M.D.		22e. ADDRESS 925 Bishop Walsh Drive, Cumberland MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 23, 1986		23c. NAME OF CEMETERY OR CREMATORY SSP Peter & Paul Cem Cumberland, Allegany MD	
24. FUNERAL DIRECTOR NAME William G. Kight		ADDRESS Cumberland, MD		25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 29 1986 <i>Julia Tisdler-Randall</i>	

Female	White	Oct. 14, 1912	VI
Kennas.	USA		
Cumberland		Red Cook	School
MD	Allegany Cumberland	13507 McAllen Hwy.	21502
Anderson	Kochis	Julia	Czechoslovak
NO	Charles S. Walbert	Cumberland, MD	

William G. Kinn
 Cumberland, MD
 Dec. 23, 1968
 Allegany MD
 13507 McAllen Hwy.

029264 JAN - 3 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove captioned papers (pages 1 and 2) and file them with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the physician must be notified at once.

BOALS FUNERAL HOME

STATE REGISTRAR 111 CHURCH STREET
WESTERNPORT, MDDEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (LAST OR PRINT) FIRST MIDDLE LAST LORNA ADEL TNE WARNICK			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 27, 1986		2b. HOUR 2:02 P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 11 1925		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HRS MIN. 61		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.		
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cashier		12b. KIND OF BUSINESS OR INDUSTRY Store	
13a. STATE W. Va.			13b. COUNTY Mineral		13c. CITY OR TOWN Keyser		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Fred B Green			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clafinda Davis					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 218 16 4195		17. INFORMANT ADDRESS Mrs. Teri Ours Keyser, W.Va. 26726			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Widespread Coronary</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis of Endocardium</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Some Coronary due to blood loss from Reduction of flow</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>12/27</u> 19 <u>86</u> , to <u>12/27</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12/27</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>[Signature]</u> DEGREE <u>MD</u>				22c. DATE SIGNED <u>12/28/86</u>			22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>SUSAN SCHWARTZ, MD</u>	
22e. ADDRESS <u>925 BISHOP WALSH DRIVE, CUMBERLAND, MD 21502</u>				23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				
23b. DATE <u>12/29/86</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cemetery</u>			23d. LOCATION <u>Barton</u> <u>Allegany, Maryland</u>			
24. FUNERAL DIRECTOR <u>[Signature]</u> NAME <u>Boals Funeral Service Westernport, Md. 21562</u>				25a. DATE REC'D. BY REGISTRAR <u>DEC 31 1986</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>		

UNITED STATES
DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

020001-100

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ALL INFORMATION CONTAINED
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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

33431

1. DECEASED NAME (TYPE OR PRINT) Alberta W. Weaver			2a. DATE OF DEATH MONTH DAY YEAR Dec. 27, 1986		2b. HOUR 2:00p M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 25, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 920 Maryland Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland				13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 920 Maryland Ave. 21502			
14. FATHER'S NAME FIRST MIDDLE LAST William Smith				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrtle E. Bell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-07-3273		17. INFORMANT ADDRESS George E. Weaver, Sr. Cumberland, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Stroke DUE TO, OR AS A CONSEQUENCE OF (c) years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/27/86 to 12/27/86 that (I) (we) last saw the deceased alive on 12/27/86 and that (I) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE W. Guy Fiscus				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/29	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. Guy Fiscus M. D.				22e. ADDRESS Memorial Ave. Cumberland, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 30, 1986		23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery Artemas Bedford Penna		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME William G. Kight Cumberland, MD				25a. DATE REC'D. BY REGISTRAR JAN 2 1987			
				25b. REGISTRAR'S SIGNATURE Lia Davidson-Randall			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate to the funeral home. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 which any injury, or other traumatic cause, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Dec. 27, 1984
Cumberland
820 Maryland Ave.
Baltimore, MD 21202
William G. Knight
Cumberland, MD
820 Maryland Ave.
Baltimore, MD 21202
Cumberland
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These permits require carbon papers. Pages 1 and 2 will be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 3 4 3 8

REG. NO.

1. DECEASED NAME (Type or Print)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST RICHARD JACKSON WHETZEL			MONTH DAY YEAR DECEMBER 20, 1986			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
MALE	WHITE	JUNE 20, 1938 ^{EAR}	48			MONTHS DAYS HOURS MIN.		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7c. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH		
ALLEGANY			USA			ALLEGANY		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			12a. USUAL OCCUPATION		
WESTERNPORT			112 WALNUT ST.			LABORER		
13a. STATE			13b. COUNTY			13c. STREET ADDRESS / ZIP CODE		
MD.			ALLEGANY			112 WALNUT ST. 21562		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		
FIRST MIDDLE LAST ANDREW JACKSON WHETZEL			FIRST MIDDLE LAST ETHEL A. TRENUM			16b. SOCIAL SECURITY NO.		
						218 34 2651		
17. INFORMANT			ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		
VIOLA WHETZEL WESTERNPORT, MD.			21562			PART I. DEATH WAS CAUSED BY:		
						IMMEDIATE CAUSE (a) <i>Carcinoma of</i>		
						DUE TO, OR AS A CONSEQUENCE OF		
						(b) <i>Carcinoma of Colon</i>		
						DUE TO, OR AS A CONSEQUENCE OF		
						(c)		
						PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
			HOUR A.M. MONTH DAY YEAR					
			P.M. 19					
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION		
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE			DEGREE			22c. DATE SIGNED		
<i>Robert W. Bess</i>						12/22/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
ROBERT W. BESS			ASHFIELD ST., PIEDMONT, WV.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
BURIAL			12/23/86			BLOOMINGTON CEMETERY		
23d. LOCATION			23e. DATE OF BURIAL			23f. REGISTRAR'S SIGNATURE		
BLOOMINGTON GARRETT, MD. STATE			DEC 24 1986			<i>John Henderson</i>		
BOAL FUNERAL SERVICE, P.A. WESTERNPORT, MD. 21562								

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8633439	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GRACE ELIZABETH WHITNEY			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 5, 1986		2b. HOUR 2:24A M
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 08-10-1901		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) PA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ret.	12b. KIND OF BUSINESS OR INDUSTRY Cloak & Suit
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Ruben Landis			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara M. Logue		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-05-7167		17. INFORMANT ADDRESS Mrs. Hazel M. Robinson, Cumberland, MD-sister	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) End stage liver disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour Years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 19____, to 19____, that (I) (we) last saw the deceased alive on 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE S. Gupta			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. GUPTA			22e. ADDRESS 69 Greene St. Cumberland, Maryland 21502		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-07-1986	23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502			25a. DATE REC'D. BY REGISTRAR DEC 09 1986		
			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 6 3 3 4 4 0

1. DECEASED NAME (TYPE OR PRINT) EDWARD JEREMIAH WILSON			2a. DATE OF DEATH MONTH DAY YEAR December 31, 1986		2b. HOUR 3:30A M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR NOVEMBER 10 1904		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.		
13a. STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM R. WILSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GERTRUDE BLANCHE JOHNSON		17. INFORMANT ADDRESS GRACE WILSON 630 BROOKFIELD AVE CUMBERLAND		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-05-4217		17. INFORMANT ADDRESS GRACE WILSON 630 BROOKFIELD AVE CUMBERLAND		
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a: _____						
19a. DATE OF OPERATION						
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20b. IF YES, WERE FINDINGS USED IN IDENTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>						
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)						
21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>12/15</u> , 19 <u>86</u> , to <u>12/31</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12/30</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.						
22b. SIGNATURE <u>Dr. Guy Fiscus</u> DEGREE						
22c. DATE SIGNED <u>31 Dec 1986</u>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Guy Fiscus						
22e. ADDRESS Memorial Hospital Medical Bldg. Cumberland, MD 21502						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 31 DEC 1986		23c. NAME OF CEMETERY OR CREMATORY ROSEDALE CREMATORY		
24. FUNERAL DIRECTOR NAME SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MARYLAND		24. FUNERAL DIRECTOR ADDRESS SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MARYLAND		25a. DATE REC'D. BY REGISTRAR JAN 5 1987		
25b. REGISTRAR'S SIGNATURE <u>John Davidson-Pandora</u>						

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please place these carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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